

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3212

## CERTIFICATE OF DEATH

03260

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>35 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Stn &amp; Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1515 Greenville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Walter Cecil</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>29</u> Year <u>1961</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-26-87</u> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> <b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plumber</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>George Dutts &amp; Co.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Worcester, England</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Thomas Allen</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Maria Thomas</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>377-03-0058-A</u>		<b>17. INFORMANT</b> <u>MR Walter F. Allen</u> Address <u>same as deceased</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized and coronary atherosclerosis</u> (c) <u>several years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Carcinoma of the rectum</u>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital), attended the deceased from</b> <u>February 1961</u> <b>to</b> <u>March 29, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 29, 1961</u> , <b>and that death occurred at</b> <u>12:30 p.m.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Bennet A. Porter, Jr.</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>March 29, 1961</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Bennet A. Porter, Jr., M.D.</u>				<b>22d. ADDRESS</b> <u>9301 Coleville Rd, Silver Spring, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>4/1/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PROSPECT HILL CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>WASHINGTON, D.C.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Jirka</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 3 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>			

(M) 1. The first part of the report  
 is a description of the  
 work done during the  
 period from 1st January  
 to 31st March 1950.  
 It is divided into two  
 main sections: (a) the  
 work done on the  
 project, and (b) the  
 work done on the  
 other projects.  
 (I) 2. The second part of the  
 report is a summary of  
 the results of the work  
 done during the period  
 from 1st January to  
 31st March 1950.  
 It is divided into two  
 main sections: (a) the  
 results of the work  
 done on the project, and  
 (b) the results of the  
 work done on the  
 other projects.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3213

## CERTIFICATE OF DEATH

03201

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN Ib 134 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 2813 Burgundy Road			
<b>3. NAME OF DECEASED</b> (Type or print) Edmund John ANDERSON		<b>4. DATE OF DEATH</b> March 27 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-17	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) New York			
13. FATHER'S NAME Edward Joseph ANDERSON			14. MOTHER'S MAIDEN NAME Ida Amele ULRICH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII-Korean		16. SOCIAL SECURITY NO. 223-50-6258		17. INFORMANT (W) Mrs. Arrietta E. Anderson, same as #2 above			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma (Primary unknown) 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 6 mos		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (X) (this hospital) attended the deceased from Nov. 9 1960 to March 27, 1961, that (X) (we) last saw the deceased alive on March 27 1961, and that death occurred at 7:23AM M, from the causes and on the date stated above.							
22a. SIGNATURE R. C. THOMAS, LT, MC, USN		22b. DATE SIGNED 3-27-61		22c. PHYSICIAN'S NAME (Type) R. C. THOMAS, LT, MC, USN			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 30, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley, 1500 W. Braddock Rd., Alexandria		25a. REC'D BY REGISTRAR Va.		25b. REGISTRAR'S SIGNATURE Charles L. Kline			
25c. LOCATION (City, town or county) Arlington		25d. DATE MAR 30 '61					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

123

1.  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

$$401 = 3 \cdot 133 + 1$$

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1942-1943



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3214

Item 2 Film 0282 3/14/61 mh

03202

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Va.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>1200 S. Courthouse Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Kathryn</i> Middle <i>Barber</i> Last <i>Barber</i>		4. DATE OF DEATH Month <i>7</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 27-1878</i>
9. AGE (In years last birthday) <i>82</i>		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>5</i> Hours <i>19</i> Min. <i>10</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Ireland</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Burke</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Malloy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Chart</i>	
17. INFORMANT <i>Chart</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>10 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 12, 1960</i> to <i>March 5, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 5, 1961</i> , and that death occurred at <i>11:00 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>James M. Whitlock</i>		22b. DATE SIGNED <i>March 6, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>		22d. ADDRESS <i>7717 Canollan Takoma Park Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>Mar 8, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Maus.</i>		23d. LOCATION (City, town, or county) (State) <i>Martinsville Indiana</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Murphy</i>		25a. REC'D BY REGISTRAR <i>Mar 9 '61</i>	
ADDRESS <i>Carl. &amp; Va</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

1914

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*[Extremely faint, illegible handwritten text covering the majority of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CERTIFICATE OF DEATH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**3215**

**03203**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5503 Charlcoate Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lida</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>22</b> Year <b>1961</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>5-10-73</b>		<b>9. AGE</b> (In years last birthday) <b>87</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - - - -		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>William WILLIAMS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Zadie KASSON</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>(D) Mrs. Frances W. B. Miller, same as #2 above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction, myocardium</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Volvulus, cecum</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <b>March 21 1961 to March 22 1961</b>		<b>20g. (County)</b> <b>6:45AM</b>		<b>20h. (State)</b> <b>March 22 1961</b>			
<b>21. I certify that (X) (his hospital) attended the deceased from March 21 1961 to March 22 1961, that (X) (we) last saw the deceased alive on March 22 1961, and that death occurred at 6:45AM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>G. A. MAGID, LT, MC, USN</b>		<b>22b. DATE</b> <b>3-22-61</b>		<b>22c. SIGNATURE</b> <b>XXXXX</b>			
<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3-24-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Arlington</b>		<b>23e. (State)</b> <b>Virginia</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 24 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Hines</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

**3216**

**03204**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>30 Years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>200 E. Wayne Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>200 E. Wayne Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Henry</b> Middle <b>W.</b> Last <b>Barrows</b>			<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>9</b> Year <b>19 61</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>February 10, 1886</b>		<b>9. AGE</b> (In years lost birthday) <b>75</b> yrs. IF UNDER 1 YEAR: Months <b>7</b> Days <b>22</b> Hours <b>1</b> Min.		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <b>Gen'l Conf, S.D.A</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Randolph, Vermont</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Willis Barrows</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Jennie Sumner</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Lillian Barrows</b> <b>200 E. Wayne Ave., Sil. Spr., Md.</b>			
<b>18. CAUSE OF DEATH</b> {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Carcinoma of Pancreas -</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m.		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 15<sup>th</sup> 1961, to March 9, 1961, that (I) (we) last saw the deceased alive on March 5, 1961, and that death occurred at 9<sup>PM</sup>, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Lysle Williams</b>				<b>22b. DATE SIGNED</b> <b>March 9, 1961</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Lysle Williams</b>				<b>22d. ADDRESS</b> <b>8700 Colesville Rd., Silver Spring, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>March 13, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>George Washington Cemetery</b>			
<b>23d. LOCATION</b> (City, town, or county) <b>Prince Georges County, Md</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Arthur Walters</b>					
<b>25. REC'D BY REGISTRAR</b> <b>DATE MAR 13 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



020

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

*[Vertical handwritten text, possibly a signature or date, located on the right side of the page.]*

(1)

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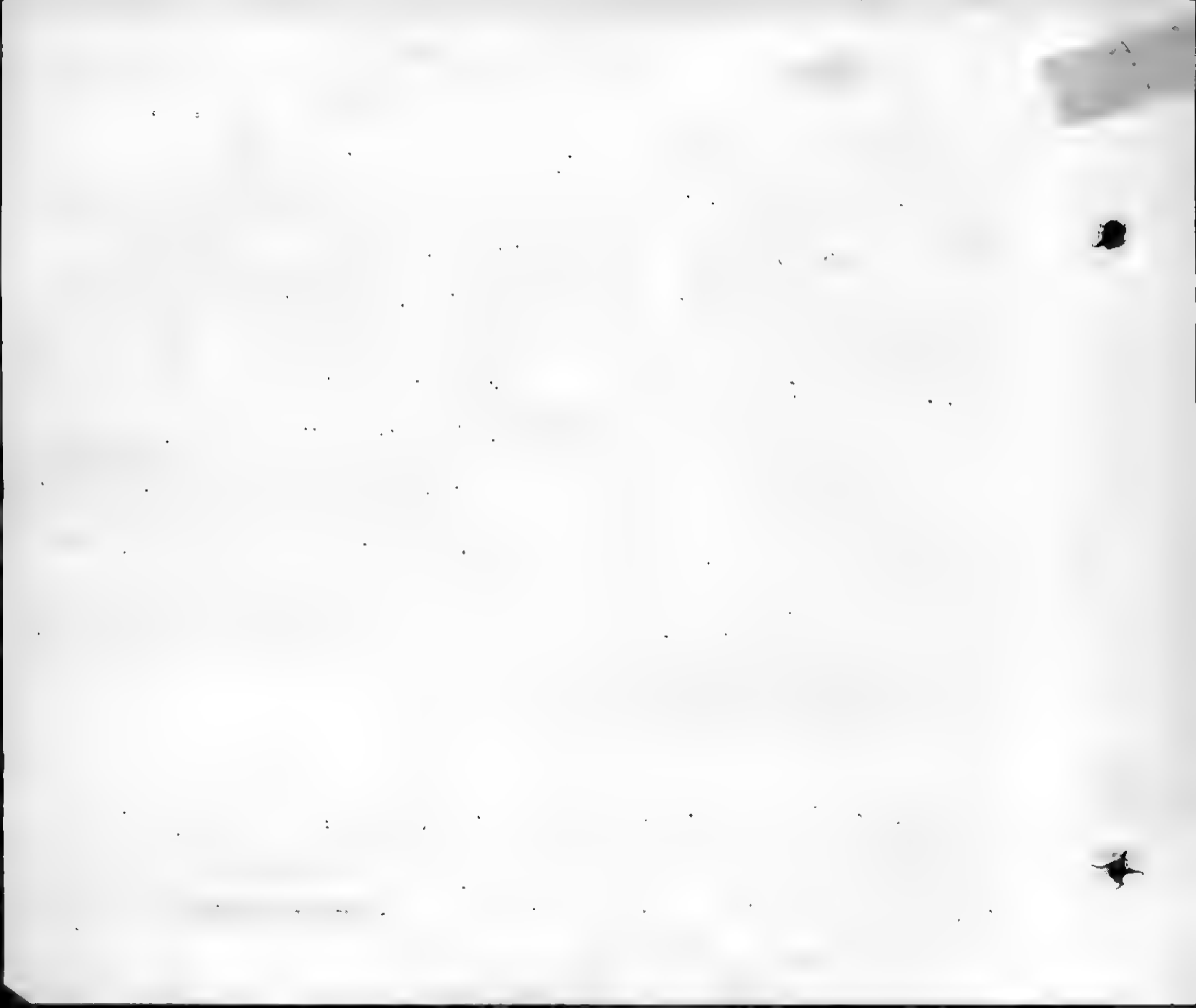
## CERTIFICATE OF DEATH

Reg. Dist. No 03206

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>DE MD</b> b. COUNTY <b>PR 600.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RUSH-SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>17 days.</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>MARLEA SANITARIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>P.</b> Last <b>BEAVERS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House wife</b>	11. BIRTHPLACE (State or foreign country) <b>WASH. DC.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>WILFORD NOTT</b>	
14. MOTHER'S MAIDEN NAME <b>AGNES ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or defense service) <b>NONE</b>	
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>EVERETT J. BEAVERS SA-625-5746</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Feb. 20, 1961</b> to <b>March 7, 1961</b> , that I last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred <b>at 10:30 P.M.</b> from the causes and on the date stated above.	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/11/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN Cem</b>		22d. LOCATION (City, town, or county) (State) <b>COLMAR MANOR PR 600, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Chambers, Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3219

113203

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>8007 18th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Beck</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>5</u> Year <u>1961</u>		<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>Cauc.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6-16-60</u>		<b>9. AGE (In years last birthday)</b> yrs. <u>8</u> Months <u>13</u> Days <u></u> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u></u>				<b>13. FATHER'S NAME</b> <u>Robert S. Beck</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Hora E. Emory</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u></u> <b>17. INFORMANT</b> <u>admission Record</u> Address <u>Washington Sanitarium</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease (Tetralogy of Fallot)</u> (b) <u>154.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>Dehydration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>				<b>20f. (City or town)</b> <u></u> (County) <u></u> (State) <u></u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/16</u> <b>19</b> <u>60</u> <b>to</b> <u>3/5</u> <b>19</b> <u>61</u> , <b>that (I) (who) last saw the deceased alive on</b> <u>3/5</u> <b>19</b> <u>61</u> , <b>and that death occurred at</b> <u>12:40</u> <b>p.m.</b> <b>from the causes and on the date stated above.</b>								<b>22a. SIGNATURE</b> <u>Eino Magi</u> <b>22b. DATE SIGNED</b> <u>3/6/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>EINO MAGI</u>				<b>22d. ADDRESS</b> <u>918 Univ. Blvd. E., Silver Spring, Md.</u>				<b>22e. REC'D BY REGISTRAR</b> <u></u> <b>25b. REGISTRAR'S SIGNATURE</b> <u></u>			
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <u>Burial</u> <u>3-7-61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Port Lincoln Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) <u>Prince George's County, Md.</u>			
<b>24. FLINER, DIRECTOR'S SIGNATURE</b> <u>J. Arthur Dallas</u>				<b>25c. ADDRESS</b> <u>254 CARROLL ST. NW WASH. 12, D.C.</u>				<b>25e. DATE</b> <u>MAR 7 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

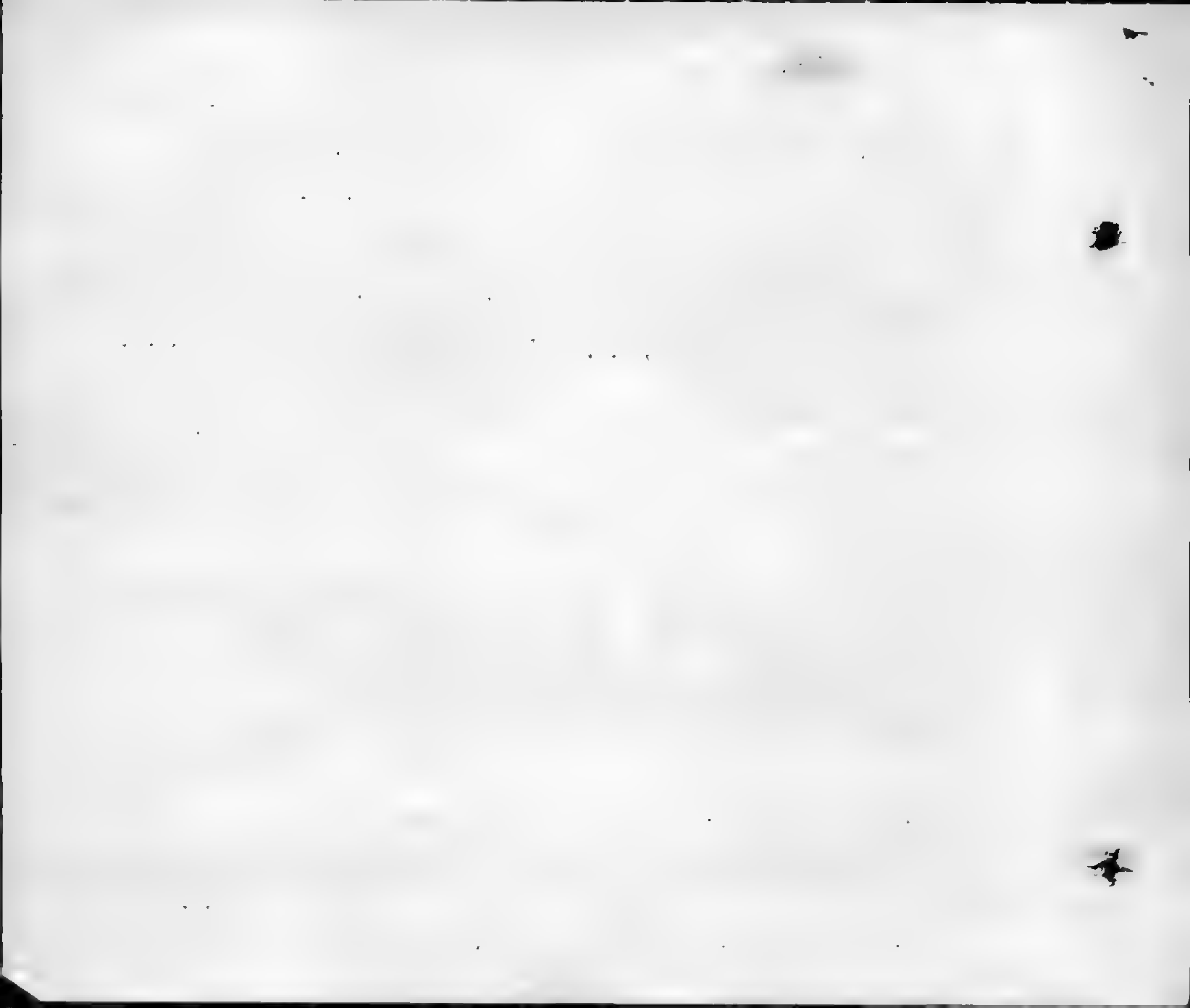
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**3220**

**03208**

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Wheaton Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton, Maryland</u> c. LENGTH OF STAY IN 1b <u>less than 1 month</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Rockville MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>129 Talbott St. Rockville, Md.</u> d. STREET ADDRESS <u>129 Talbott St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3 NAME OF DECEASED</b> (Type or print) First <u>HENRY</u> M'ddle <u>ALBIN</u> Last <u>BERNHARD</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 28, 1886</u> 9. AGE (In years lost birthday) <u>75</u> yrs 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Packer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Tobin Packing Co. Albany, N.Y.</u> 11. BIRTHPLACE (State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				<b>4 DATE OF DEATH</b> Month <u>March</u> Day <u>19</u> Year <u>1961</u> IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS					
<b>13. FATHER'S NAME</b> <u>FREDERICK BERNHARD</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>CAROLINE (unknown)</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO</b> <u>78-05-2300</u> <b>17. INFORMANT</b> <u>Wheaton Nursing Home</u> Address <u>11901 Ga. Ave. Wheaton, Md</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>334X</u> DUE TO (b) <u>Hypertension</u> Condition, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Osteoarthritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>? yrs</u> <u>? yrs</u>	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day Year Hour o. m. p. m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 1960</u> , to <u>March 19, 1961</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>March 18, 1961</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.								<b>22a. SIGNATURE</b> <u>Robert A. Hare</u> M.D. <b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert A. Hare</u> <b>22d. ADDRESS</b> <u>7600 Carroll Ave. Tak. PK. Md</u> <b>22b. DATE SIGNED</b> <u>3/19/61</u>	
<b>23a. BURIAL, CREMATION OR REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3/21/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PROSPECT HILL CEMETERY</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>WASHINGTON, D.C.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Purcell, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				<b>25a. REG'D BY REGISTRAR</b> <u>MAR 23 61</u> DATE		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Hume</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3221

## CERTIFICATE OF DEATH

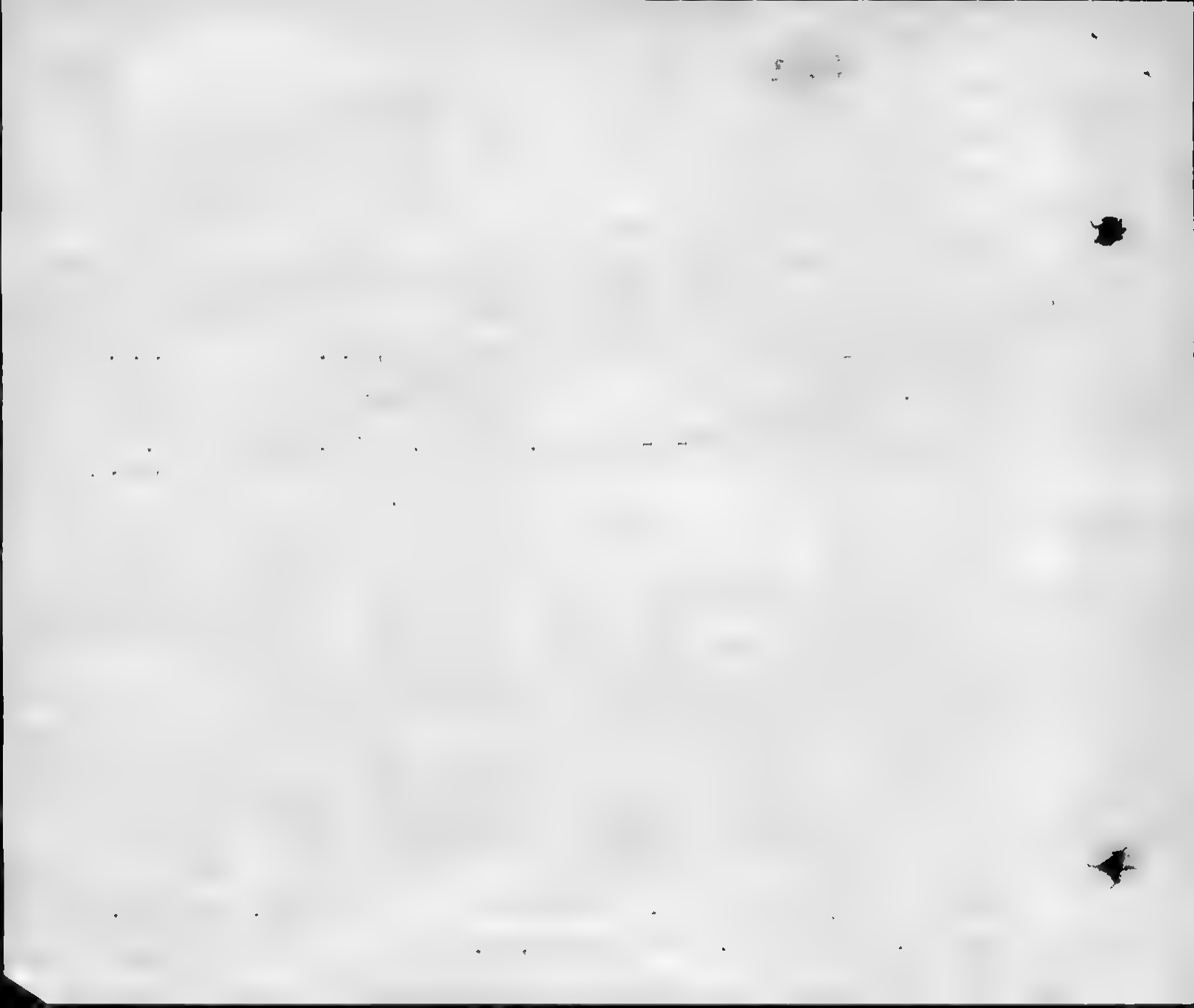
03209

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>5 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8919 1st Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNA ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EDGEWATER</b> d. STREET ADDRESS _____			
<b>3. NAME OF DECEASED</b> (Type or print) <b>RAYMOND HENRY BIRCH</b>			<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>8</b> Year <b>1961</b>				
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <b>6/21/01</b>			
<b>9. AGE</b> (In years, last birthday) <b>59</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Taxi driver - own cab</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WASHINGTON, D.C.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>JAMES A. BIRCH</b>					
<b>14. MOTHER'S MAIDEN NAME</b> <b>EMMA SPINKS</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>579-09-6154</b>				<b>17. INFORMANT</b> Address <b>Mrs. Goldie M. Nalley, 8919 1st Ave. Silver Spring,</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>manicure</b> Conditions, if any, which gave rise to immediate cause (b) <b>baronoma of pharynx</b> (c) <b>baronoma of pharynx</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>20g. (County)</b> _____		<b>20h. (State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from... Dec. 1960 to March 8, 1961, that (I) (we) last saw the deceased alive on Feb. 28, 1961, and that death occurred at 6:35 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Jules I. Caman</b>				<b>22b. DATE SIGNED</b> <b>March 8, 1961</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JULES I. CAMAN</b>				<b>22d. ADDRESS</b> <b>1015 SPRING ST. SILVER SPRING, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>3/11/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FT. LINCOLN CEMETERY</b>			
<b>23d. LOCATION (City, town or county)</b> <b>PRINCE GEO. COUNTY, MD.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 14 1961</b>					
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Julius E. Ponder, Inc.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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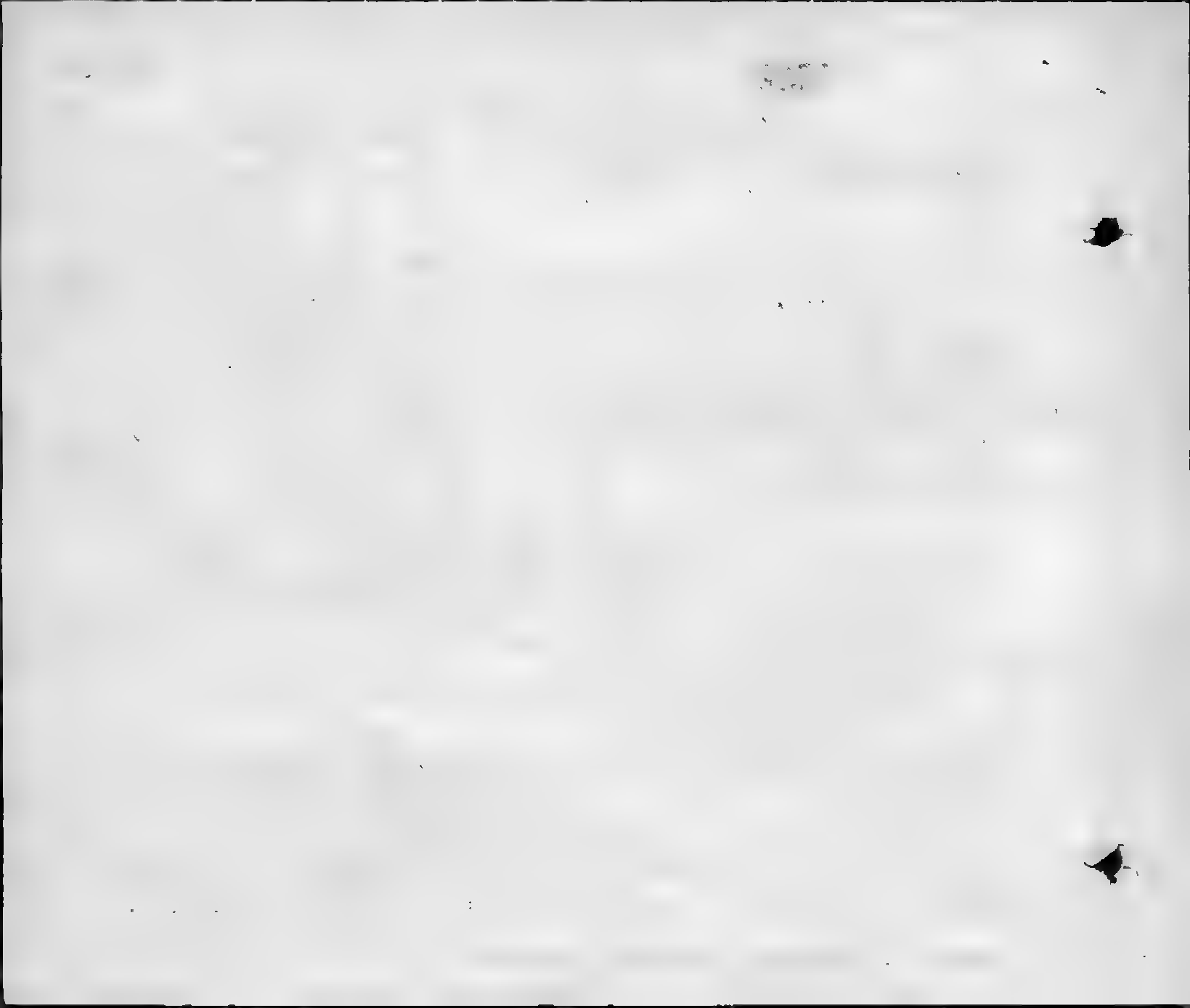


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and return it to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and return it to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3222  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03210

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst'l on Res. before adm'ss on) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>1380 4. 1102 1st St. D.</u>	
3. NAME OF DECEASED (Type or print) First <u>Miriam</u> Middle <u>B.</u> Last <u>Bishop</u>		4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/88</u>
9. AGE (in years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Halifax Nova Scotia Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Frederick W. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Boyd Rhind</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Thomas M. Sauer</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Carcinoma of sigmoid?</u> DUE TO (c) <u>C. perforation.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/11/61</u> to <u>3/13/61</u> , that (I) (we) last saw the deceased alive on <u>3/13/61</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. J. Brennan</u> M.D.		22b. ADDRESS <u>Bethesda, Md</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>		22d. ADDRESS <u>Bethesda, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>MAR 16 61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

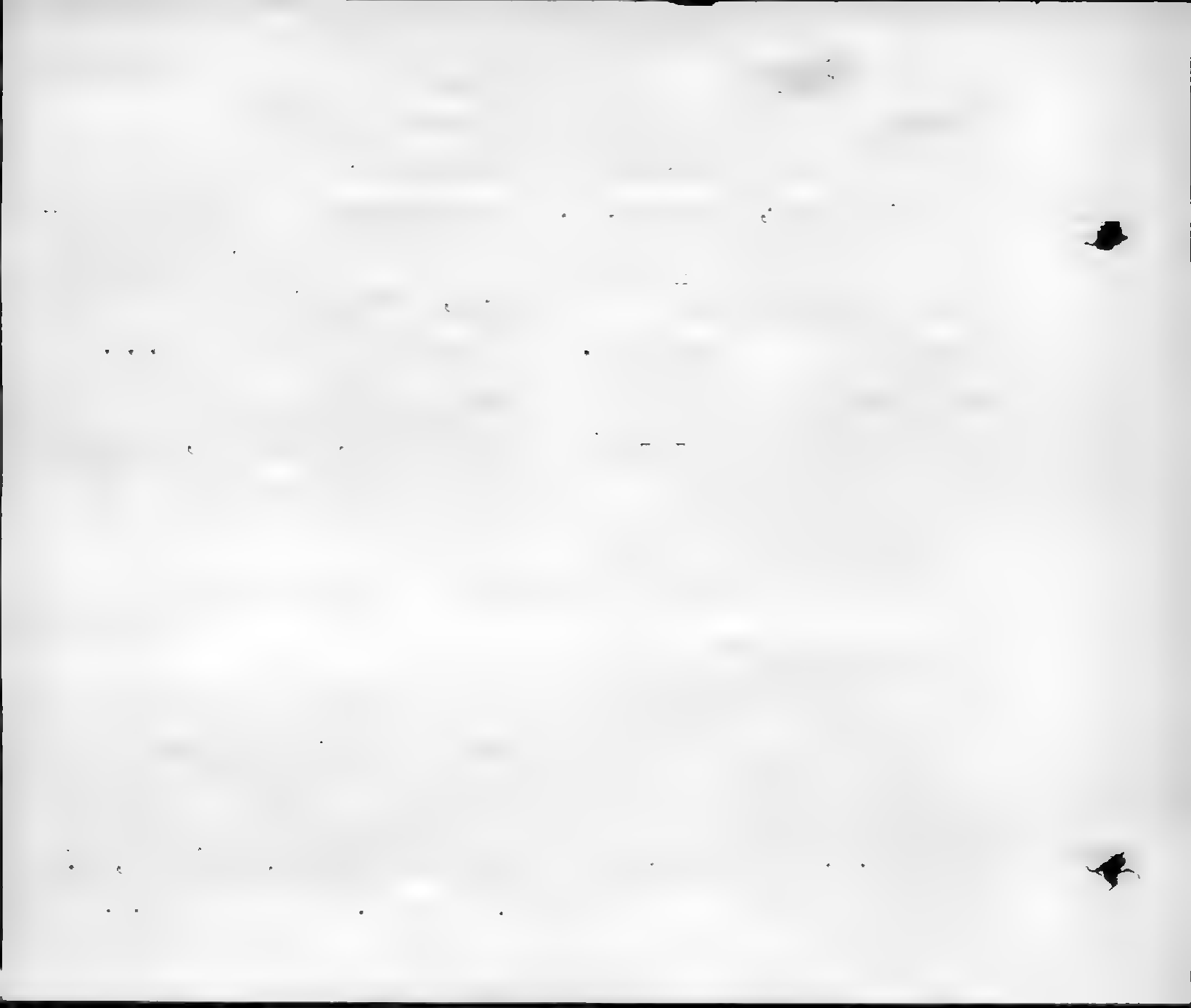
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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03211

3223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Point Pleasant</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>67x</b> d. STREET ADDRESS <b>282 Sudbury Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>(None)</b> Last <b>Blecker</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 9, 1906</b>	
9. AGE (in years last birthday) <b>54</b>		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min <b>54</b>		11. IF UNDER 24 HRS Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min <b>54</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Henry Blecker</b>				14. MOTHER'S MAIDEN NAME <b>Frances Hertwig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO <b>139-09-7175</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation, Intra-Operative</b> DUE TO (b) <b>Severe Aortic Valve Incompetency</b> DUE TO (c) <b>Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>411X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 Minutes</b> <b>Years</b> <b>Since Childhood</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>March 5, 1961</b>	
20f. (City or town) <b>March 7, 1961</b>				20g. (County) <b>March 7, 1961</b>		20h. (State) <b>March 7, 1961</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>March 5, 1961</b> to <b>March 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>12:55pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. W. GILBERT, M.D.</b>				22b. DATE <b>3-8-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. W. GILBERT, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>				23b. DATE THEREOF <b>3/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Mem. Park Cem. Kenilworth, N.J.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wash S. D.C.</b>				25a. REC'D BY REGISTRAR <b>MAR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Wash S. D.C.</b>	

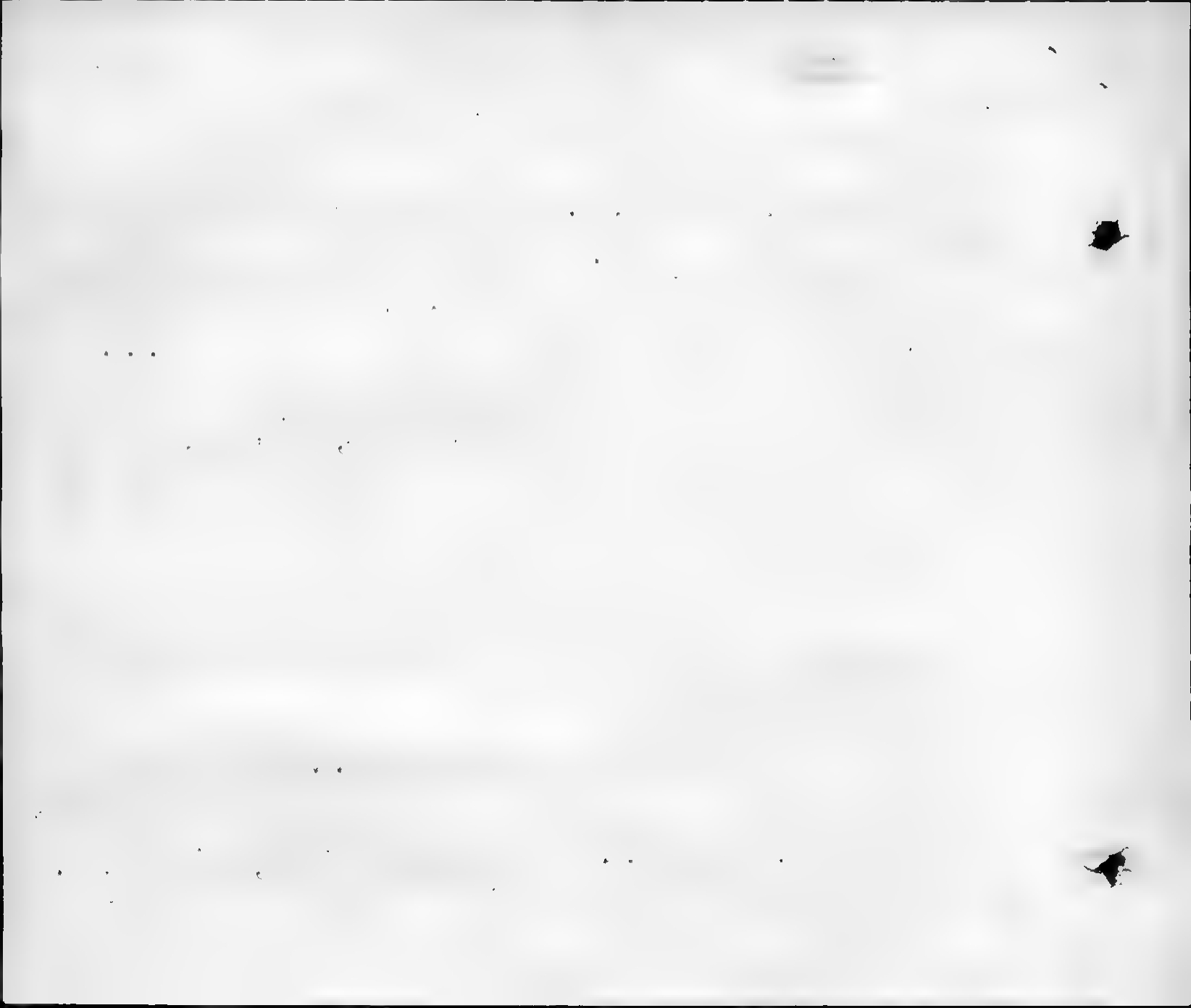




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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3224  
CERTIFICATE OF DEATH 03212

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>25 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>10550 MacArthur Boulevard</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>F.</b> Last <b>Bodine</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29, 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Bodine</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Stone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>February 15, 1961</b> , to <b>March 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1961</b> , and that death occurred at <b>12:50 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert B. Scoggins</b> M.D.				22b. DATE SIGNED <b>3/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>ROBERT B. SCOGGINS, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>				DATE <b>MAR 16 '61</b>			

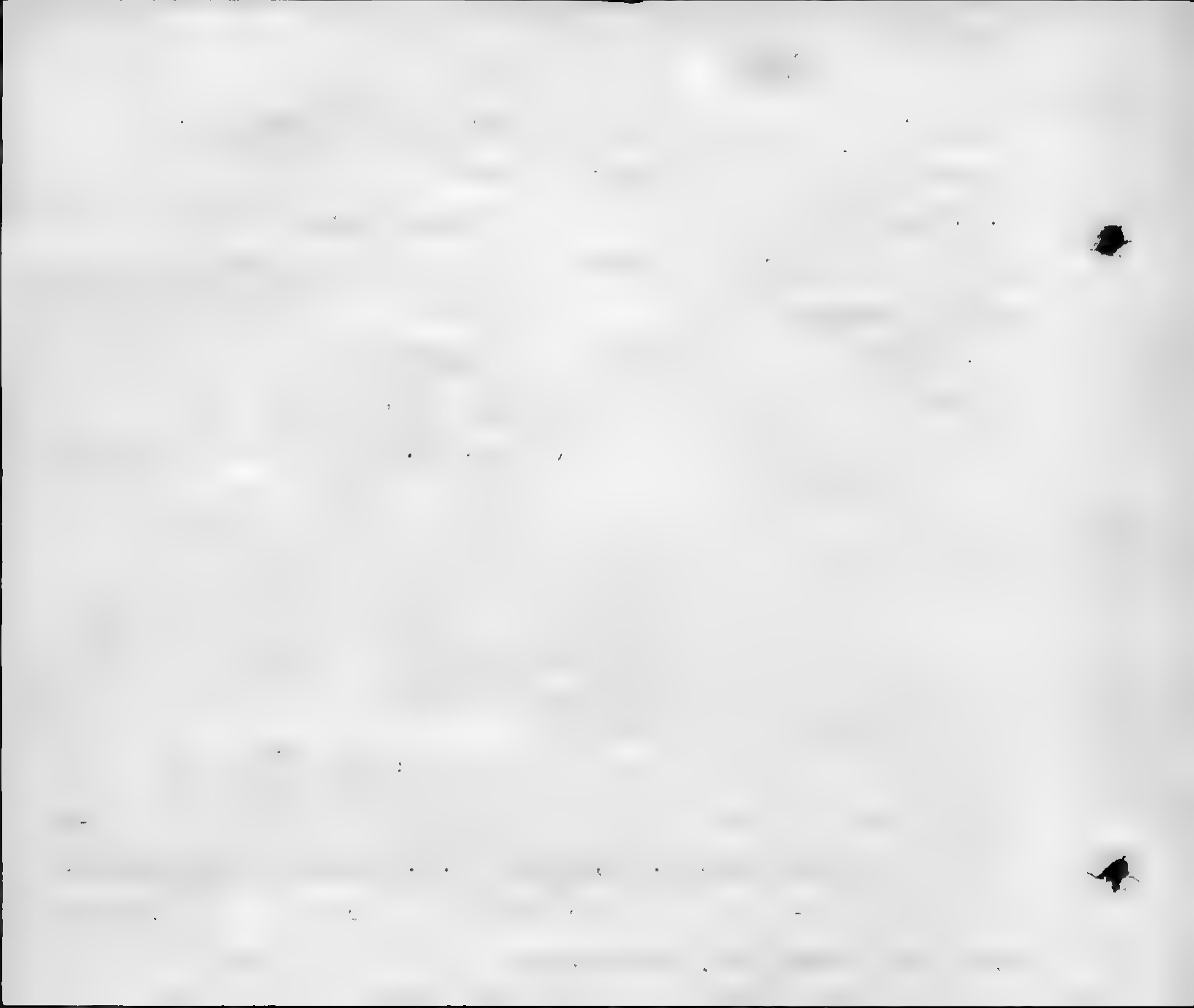


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3225  
CERTIFICATE OF DEATH

03213

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN IN <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>4501 Gretna Street</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Frederick BOHN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-17-81</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grain Buyer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Dakota</b>	
13. FATHER'S NAME <b>Frederick BOHN</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta JANN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>(S) Capt. C.L. Bohn, DC, USN, same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, bronchogenic &amp; Metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Feb. 16, 1961</b> to <b>March 1, 1961</b> , that (X) (we) last saw the deceased alive on <b>March 1, 1961</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Russell Miller, Jr. LT (MC) USN</b>		22b. DATE SIGNED <b>3-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Russell MILLER, JR., LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>3-2-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frankfort Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frankfort So. Dakota</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

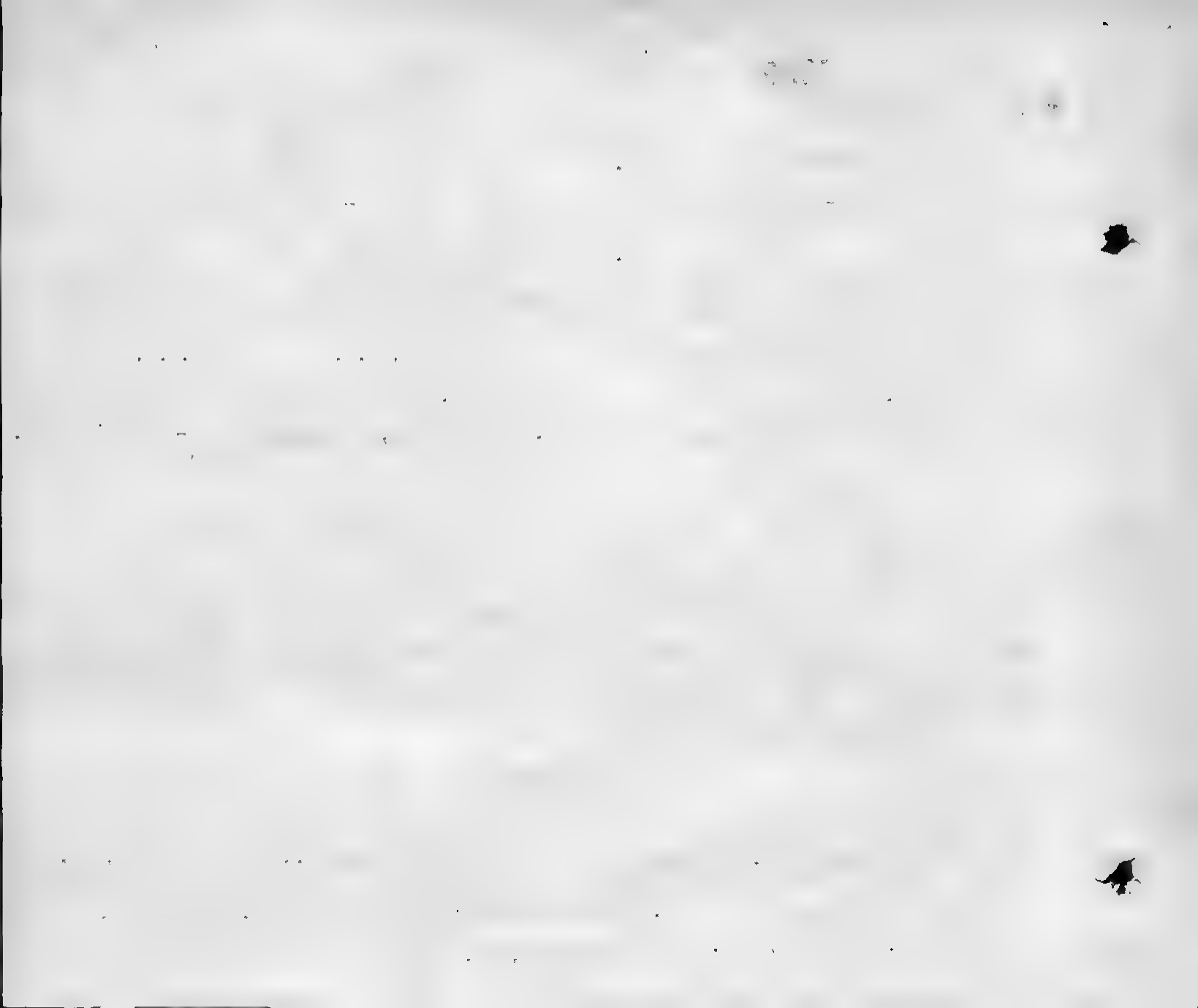
3226

03214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>1 yr.</b>		d. STREET ADDRESS <b>1300 COLESVILLE-BELTSVILLE ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1300 COLESVILLE-BELTSVILLE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>E.</b> Last <b>BOWMAN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/88</b>
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM F. KING</b>		14. MOTHER'S MAIDEN NAME <b>CORA V. CRUMP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Bessie King, 1300 Colesville-Beltsville Rd. Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b> <b>443 X</b> DUE TO (b) <b>Arteriosclerosis Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Fracture Left Hip</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis - partial Right Hemiplegia (7 yrs)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>3:45</b> p.m. <b>3:45</b> 19 <b>61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>March 1, 1961</b>	
21. I certify that (if this hospital) attended the deceased from <b>March 1, 1961</b> to <b>March 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 1, 1961</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Kenneth F. Laughlin</b>		22b. DATE SIGNED <b>March 1-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>KENNETH F. LAUGHLIN</b>		22d. ADDRESS <b>934 Ellsworth Dr., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/4/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b> <b>Edmund A. Gaska</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

BP-200

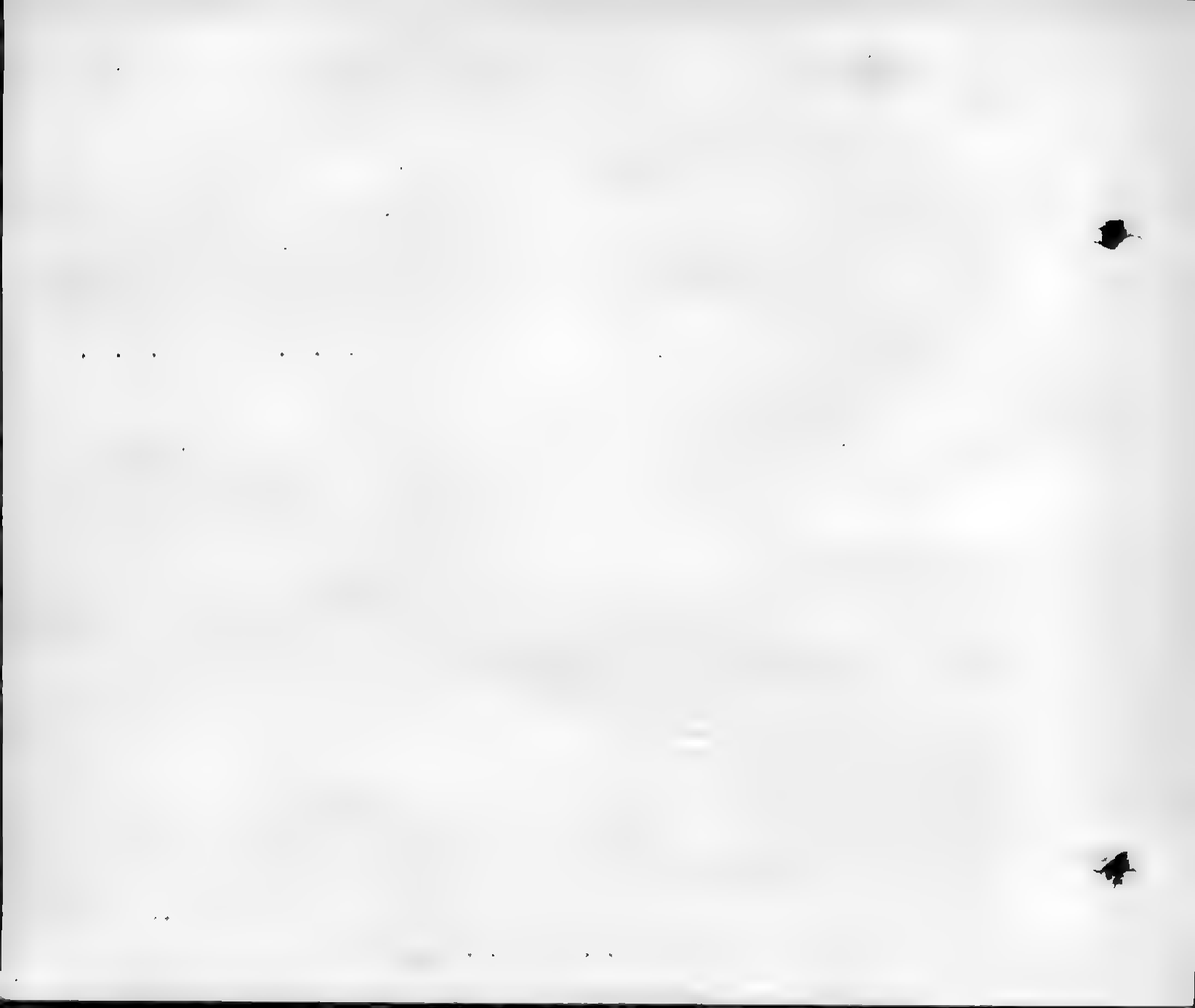


MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3227 Item 2 Film G-05 3/16/61 2wk  
**CERTIFICATE OF DEATH**

03215

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8865 Piney Branch Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Emma Bratburd</u>		4. DATE OF DEATH Month Day Year <u>March 15, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1899</u>
9. AGE (In years lost birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gustave Baumbach</u>		14. MOTHER'S MAIDEN NAME <u>Virginia ? ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Eddie Bratburd</u>		Address <u>8865 Piney Branch Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Pulmonary Edema</u> DUE TO <u>Partial Obstruction</u> (b) <u>155.1</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>10 days</u> DUE TO <u>Carcinoma of Gall Bladder</u> (c) <u>3 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>12/24, 1960</u> to <u>3/15, 1961</u> , that (I) (we) last saw the deceased alive on <u>3/14, 1961</u> , and that death occurred at <u>2:14</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis X. Richardson</u> M.D.		22b. DATE SIGNED <u>3/16/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson</u>		22d. ADDRESS <u>11412 Viers Mill Rd. Wheaton, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 16, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St, N.W. Wash, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 16 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	









1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

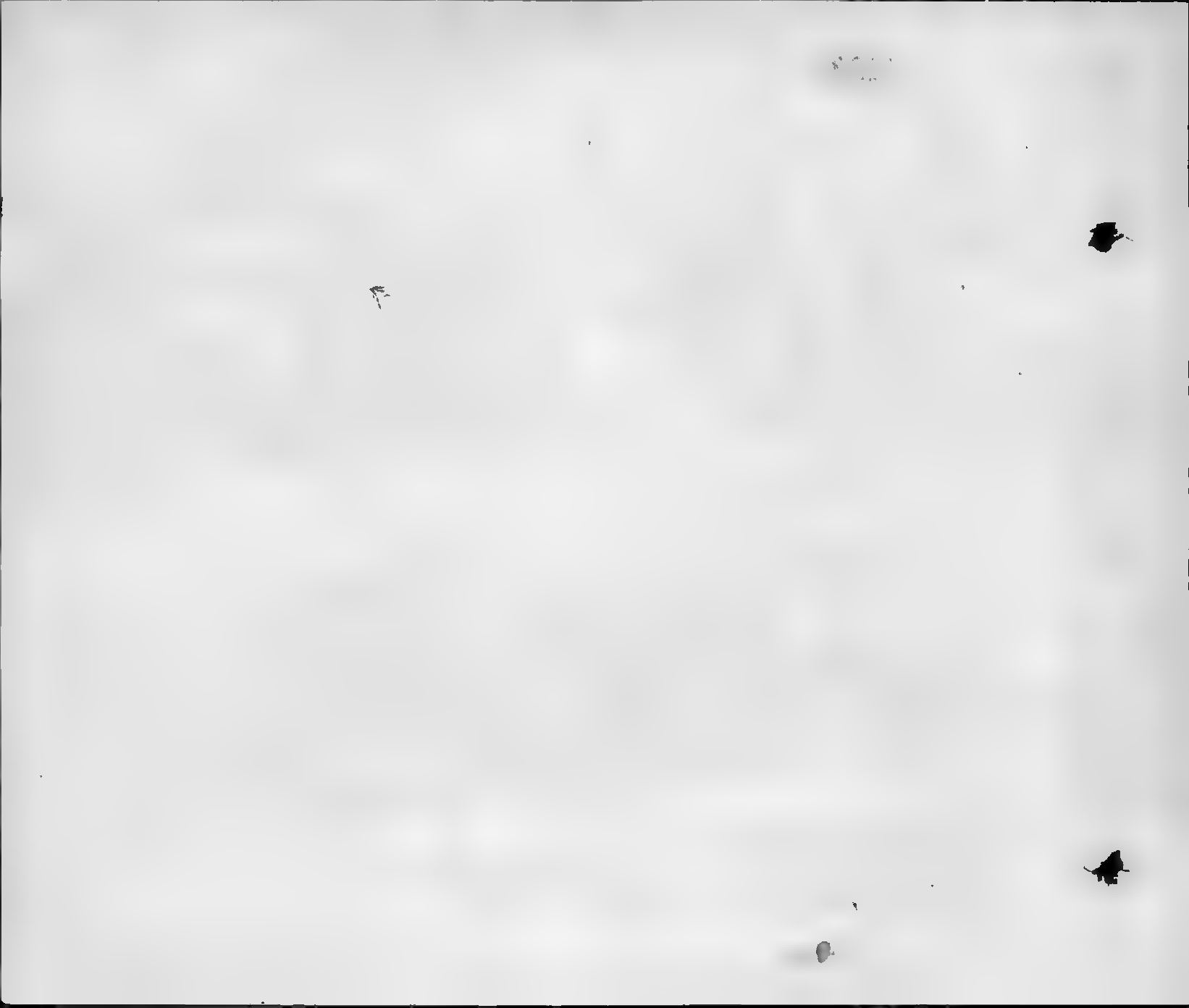
VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>Middlesex</u>	
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Revere</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Str. Hosp.</u>		d. STREET ADDRESS <u>51 Highland St</u>	
3. NAME OF DECEASED (Type or print) <u>Strah Brooks</u>	DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1961</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswh</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Roumania</u>	12. CITIZEN OF WHAT COUNTRY? <u>Roumanian</u>
13. FATHER'S NAME <u>Harry Greenberg</u>	14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mr. Samuel Brooks</u>	Address <u>Same as deceased</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary occlusion</u> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloesch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 28, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TIFARETH ISRAEL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>EVERETT MASS</u>	
23. FUNERAL DIRECTOR <u>Bruno J. Adams</u>		ADDRESS <u>3501-14th Ave</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>William J. Kline</u>	
DATE <u>MAR 28 '61</u>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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X  
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03218

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN b. <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>127 EASTMOOR DRIVE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>127 EASTMOOR DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM EDWARD BROOKS</b>		4. DATE OF DEATH Month Day Year <b>MARCH 19 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/1/90</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ass't. Cashier (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Riggs Nat'l Bank</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES E. BROOKS</b>		14. MOTHER'S MAIDEN NAME <b>MOLLIE WYLIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-22-1916</b>	
17. INFORMANT Address <b>Mrs. Margaret M. Brooks, 127 Eastmoor Dr. Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>CORONARY OCCLUSION</b> IMMEDIATE CAUSE (a) <b>201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>201</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>SUDDEN</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/22/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR Name <b>Raymond A. Ziska</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>MAR 23 '61</b> DATE	
VS. AT5ME 5M 7/59		24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3231

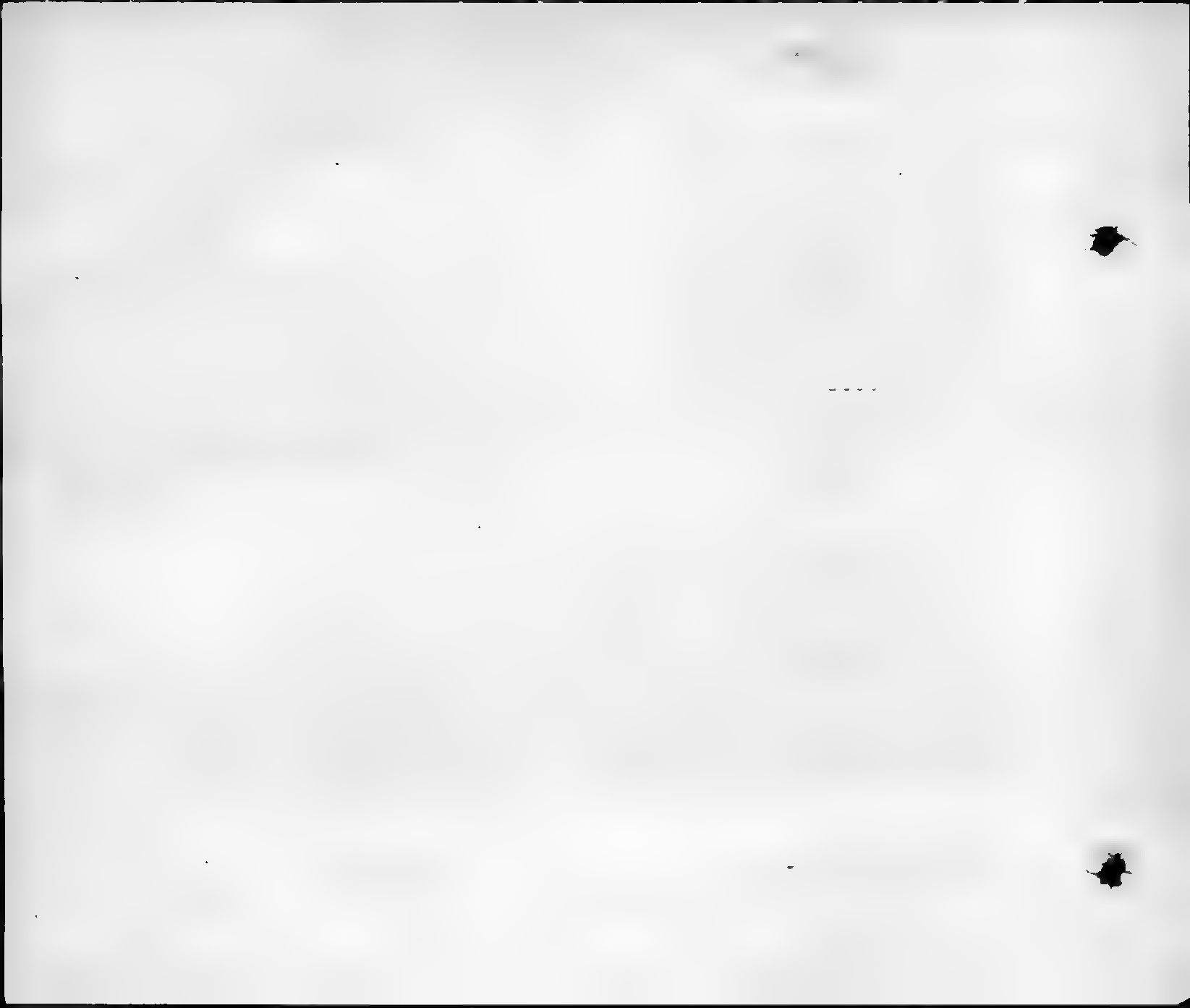
03219

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>			
c. LENGTH OF STAY IN 1b <u>2 hrs.</u>				d. STREET ADDRESS <u>3604 Upshur St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Winfield Brown</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/23/85</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		12. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Government Printing Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D. C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Scott Winfield Brown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Wife - Mrs. Caroline Brown</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							<u>4 hrs.</u>
DUE TO (b) <u>Coronary Thrombosis</u>							<u>4 hrs.</u>
DUE TO (c) <u>Coronary Artery Sclerosis</u>							<u>4 yrs.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>a.m.</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1951</u> to <u>Mar 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 22, 1961</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Robert B. Trey</u>				22b. DATE SIGNED <u>Mar 22, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. TREY</u>				22d. ADDRESS <u>7105 Ridge Rd. Huntville, AL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Antony Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL, DIRECTOR'S SIGNATURE <u>Mailly Funeral Home</u>				ADDRESS <u>not known, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

(M)

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3232

13220

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensburg</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>17 F.D. #3 - Watkins Mill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mattie Jane Campbell</u>				DATE OF DEATH Month Day Year <u>March 30 1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife &amp; cook domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>			
11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Washington</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Long</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Ella Effett - Greensburg, Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for a., (b) and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency, acute</u> DUE TO (b) <u>Hypertensive cardiovascular renal disease</u> DUE TO (c) <u>442X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>3/26/61</u> to <u>3/30/61</u> , that (2) (we) last saw the deceased alive on <u>3/30/61</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert N. Coale</u>				22b. DATE SIGNED <u>3/31/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>				22d. ADDRESS <u>4630 Montgomery Ave., Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		23d. LOCATION (City, town or county) (State) <u>Laytonville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				25a. REC'D BY REGISTRAR <u>APR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

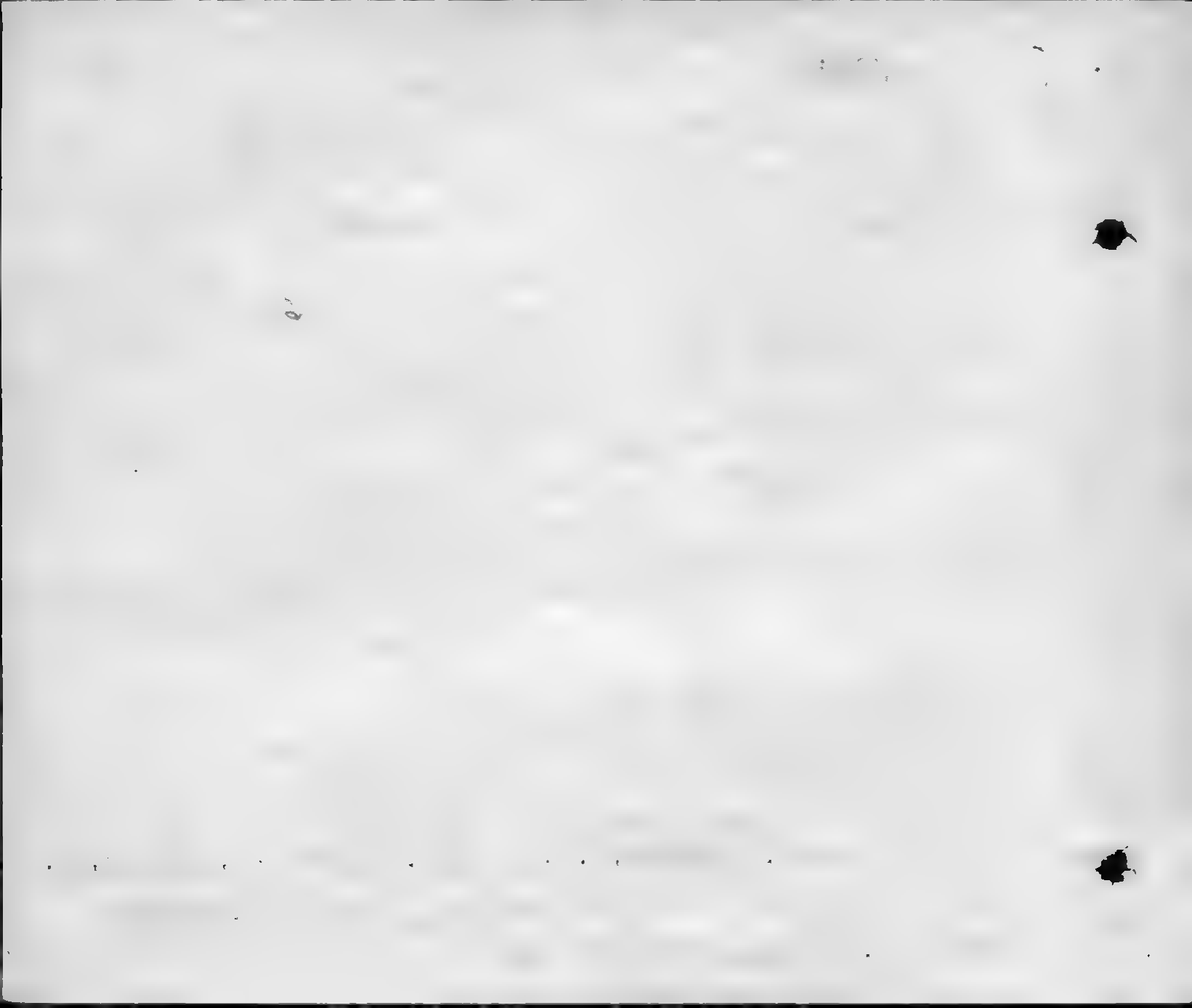
VR A15 (4)  
15M 9/60

3233

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03221

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>303 Woodland Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl Elsie Carter</u> First Middle Last 4. DATE OF DEATH <u>March 16 1961</u> Month Day Year		9. AGE (in years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>29</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/17/05</u>		11. BIRTHPLACE (County & State or foreign country) <u>md.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school bus driver Board of Education</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 13. FATHER'S NAME <u>Elsie Carter</u> 14. MOTHER'S MAIDEN NAME <u>Minnie Carter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>Yes Unknown</u> 17. INFORMATION Address <u>Pearl L. Carter/wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Essential Hypertension</u> (c) <u>CORONARY ARTERY DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>10 yrs</u> <u>104 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 13, 1956</u> to <u>MARCH 16 1961</u> , that (I) (we) last saw the deceased alive on <u>MARCH 16 1961</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		22b. DATE SIGNED <u>17 MAR 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger, M. D.</u>		22d. ADDRESS <u>310 W. Montgomery Ave, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Darnestown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3234  
CERTIFICATE OF DEATH

03222

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6612 ALLEGHENY AVE.</u>		d. STREET ADDRESS <u>6612 ALLEGHENY AVE 1</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>F.</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 8, 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. BLDG TRADES</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE COUNTY, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DAVIS CARTER</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE FORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mrs. LOTTIE C. CARTER, 6612 ALLEGHENY AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the right lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis &amp; emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 6, 1961</u> to <u>March 26, 1961</u> that (I) (we) last saw the deceased alive on <u>March 24, 1961</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jason Geiger</u> M.D.		22b. DATE SIGNED <u>3-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>		22d. ADDRESS <u>110 SPRING STREET SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>MAR. 29, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CHURCH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>FOREST GLEN, MONTG CO., MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Pelleg</u> ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 29 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

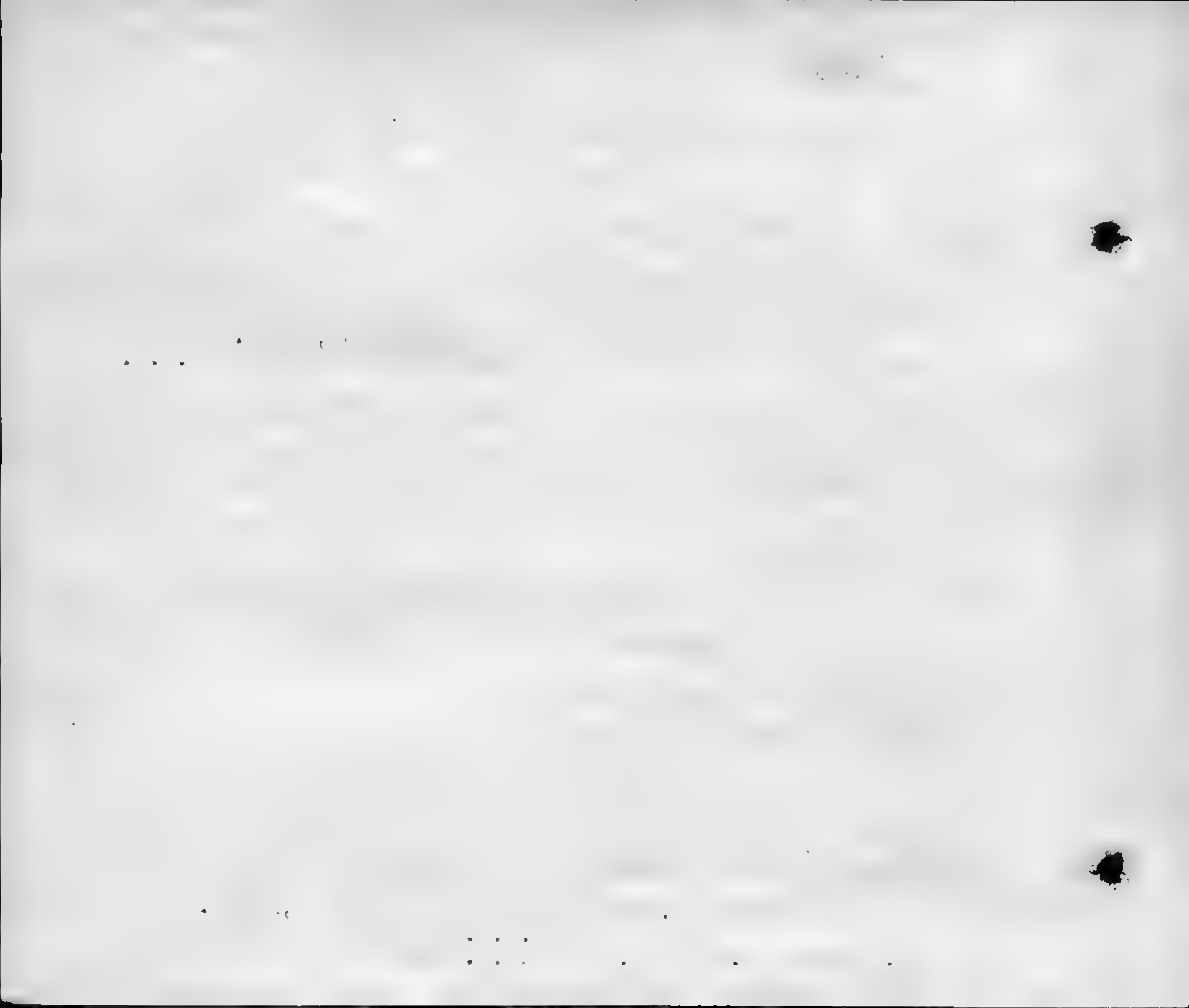


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FOR STATE  
HEALTH DEPT. (M)  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rapine Nursing Home</u>		d. STREET ADDRESS <u>15th St. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>Casey</u> Last <u>Casey</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>SUGAR NOTCH, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McNamee</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tracy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Record</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address <u>Nursing Home Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumo-pneumonia</u> 104.7 DUE TO (b) <u>Fracture Rt hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Diabetes Mellitus - months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell to floor in Nursing Home</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 - 3-1-1961</u>		20d. INJURY OCCURRED <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 27-1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/29/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS CEMETERY</u>		22d. LOCATION (City, town, or country) <u>ASHLEY, PENNA.</u>	
23. FUNERAL DIRECTOR <u>MARTIN W. HYSOING CO. 1300 N. STREET, N.W.</u>		24a. REC'D BY REGISTRAR <u>WASH. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>C. E. Kline</u>		DATE <u>MAR 29 '61</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3236

## CERTIFICATE OF DEATH

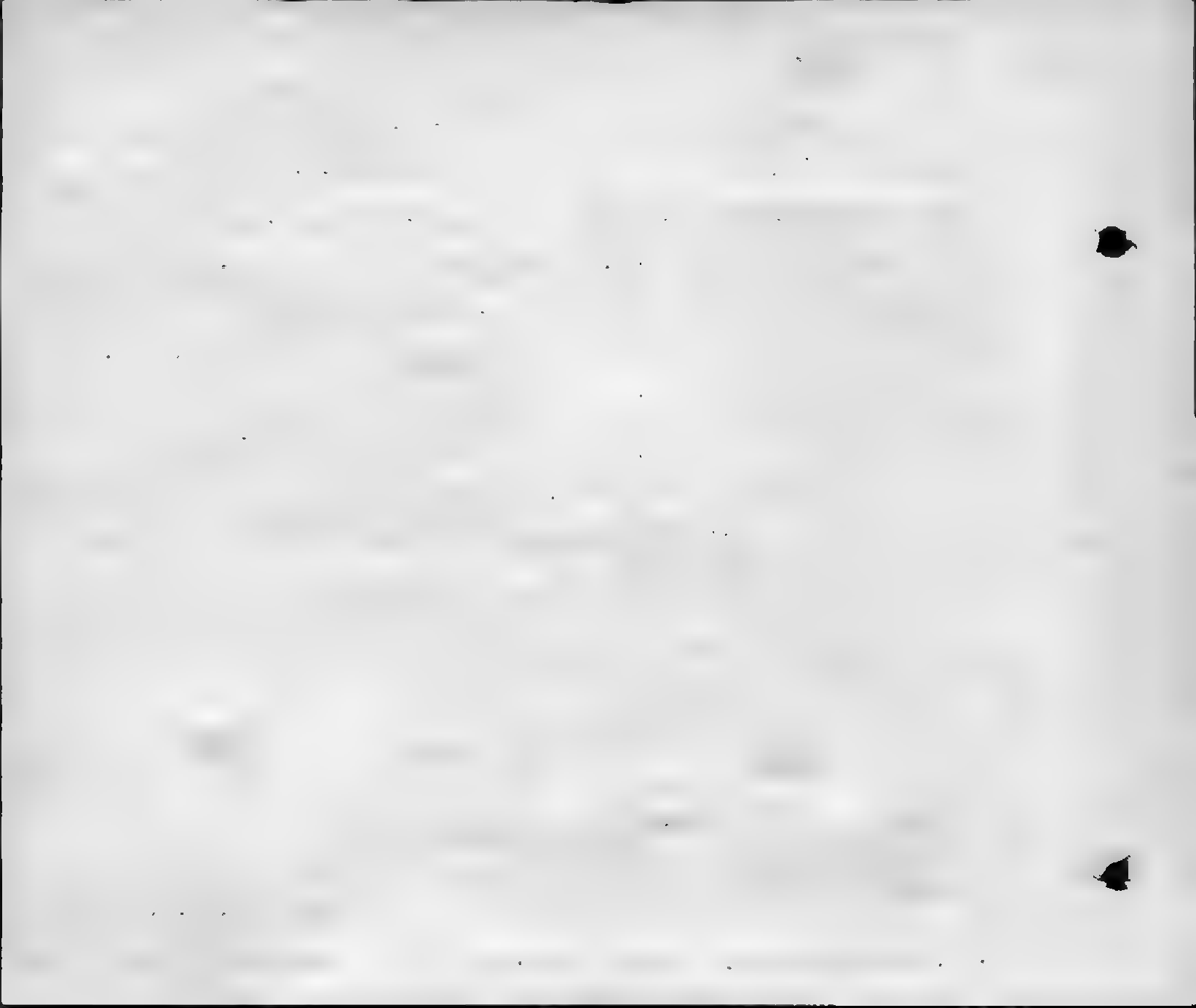
03224

Item 12 Film G285 4/17/61 mb

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington <del>Working</del> Gardens</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>110-E. Street N.W.</u> d. STREET ADDRESS <u>110-E. Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>May T. Cerceo</u> First Last Middle		<b>4. DATE OF DEATH</b> <u>March 15, 1961</u> 19 Month Day Year	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept. 2-1874</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>9. AGE</b> (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Italy</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>George Yasaelli</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Erminia Falcone</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Mrs. Josephine Grove-daughter</u> Address <u>110-E. St. N.W.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>Conjunctive Heart Failure</u> IMMEDIATE CAUSE (a) <u>150.00</u> DUE TO <u>Arteriosclerosis - Hardened</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Senility</u> (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>39</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>3/15/61</u> to <u>3/15/61</u> , that (I) (we) last saw the deceased alive on <u>3/15/61</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>SAM ALLEN, M.D.</u> Kensington, Maryland		<b>22b. DATE SIGNED</b> _____	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>SAM ALLEN, M.D.</u> Kensington, Maryland		<b>22d. ADDRESS</b> _____	
<b>23a. BURIAL, CREMATION, OR OTHER DISPOSITION</b> (Specify) <u>3/18/61</u>		<b>23b. DATE</b> _____ <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet Cem.</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Washington, D.C.</u> (State) _____		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J.Wm. Lee's Sons Co.</u> ADDRESS <u>300-4th St. N.E.</u>	
<b>25a. REC'D BY REGISTRAR</b> _____ DATE <u>MAR 17 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



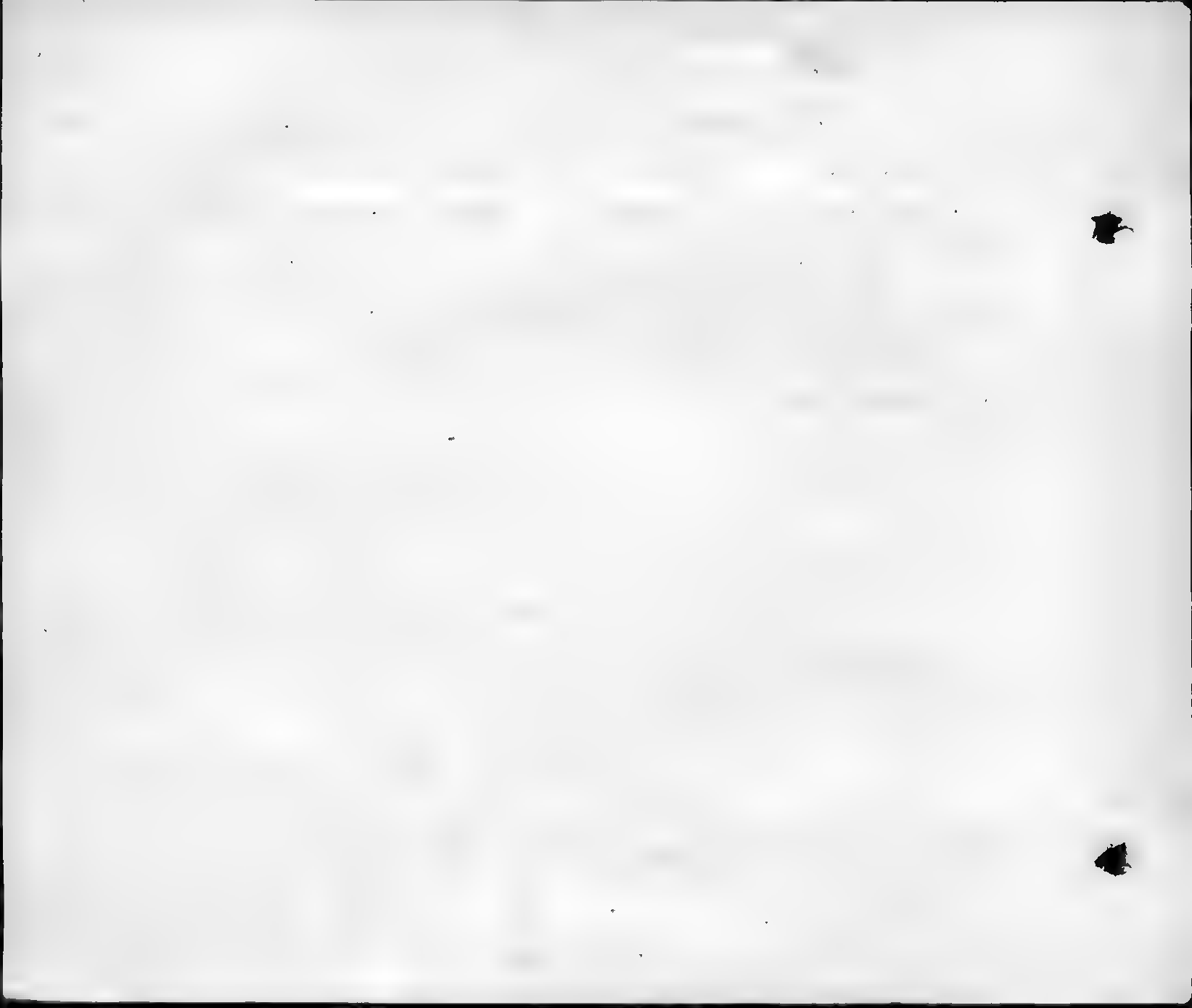
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

3237  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03225

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4408-WALSH STREET</b>		d. STREET ADDRESS <b>4408 WALSH STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAURA TENNANT CHUBB</b>		4. DATE OF DEATH Month Day Year <b>MARCH 24 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 18, 1871</b>
9. AGE (In years lost birthday) <b>89</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GOELM. TENNANT</b>		14. MOTHER'S MAIDEN NAME <b>ELLA ADEL DICKERSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT Address <b>MRS. ERNESTINE QUINN - 4408 WALSH ST.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Ventricular Failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c) <b>20 yr</b>			INTERVAL BETWEEN ONSET AND DEATH <b>22 minutes</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1952</b> to <b>March 24, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>3/23</b> 19 <b>61</b> , and that death occurred at <b>4:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm Fleet Luckett</b> M.D.		22b. DATE SIGNED <b>3-24-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm Fleet Luckett</b>		22d. ADDRESS <b>5000 IRING RD NW DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>3-24-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Don. DeVol</b> ADDRESS <b>2224-Wis. Ave. N.W.</b>		25a. REC'D BY REGISTRAR <b>DAMAR 27 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



CERTIFICATE OF DEATH

Reg. Dist. No.

03226

2238

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring.,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>H.</b> Last <b>Claggett</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>A A</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6 1882</b>		9. AGE (In years last birthday) yrs. <b>78</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Marshall Claggett</b>				14. MOTHER'S MAIDEN NAME <b>Leanna Wallace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Alice E. Claggett</b> Address <b>Brooke Road., Sandy Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiorenal Disease with Edoema</b> <b>260X</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bubobocoele. Bronchial Asthma. Auricular Fibrillation.</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 25</b> , 19 <b>58</b> , to <b>March 15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 14</b> , 19 <b>61</b> , and that death occurred at <b>1:12 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Norbeck Rt. 1 Silver Spring, Md.</b> DATE SIGNED <b>3/17/61</b>							
ACTUAL SIGNATURE <b>Webster Sewell</b>		PHYSICIAN'S NAME (Type) <b>Webster Sewell</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/18/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 23 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3239

## CERTIFICATE OF DEATH

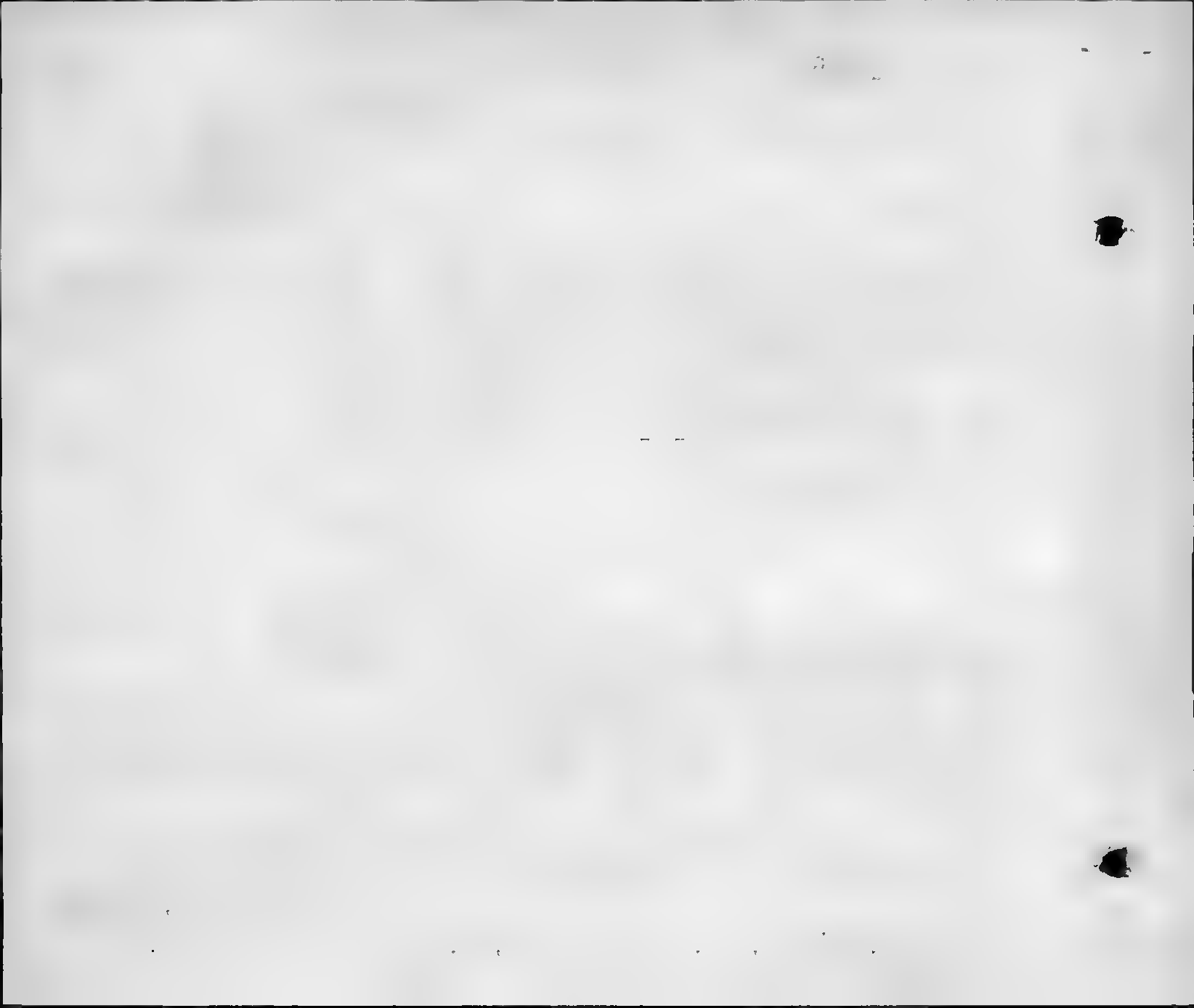
Item 2 Film G204 4/13/61 1wk

03227

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>CALIFORNIA</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANONYM TARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD</u>	
c. LENGTH OF STAY IN 1b <u>4.1 yrs</u>		d. STREET ADDRESS <u>289 Maple Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Clemmer</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Duty</u>	
13. FATHER'S NAME <u>William Howard</u>		14. MOTHER'S MAIDEN NAME <u>Martha Shipman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>554-22-1496</u>	
17. INFORMANT <u>p/t Hospital record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Chronic coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Chronic aneurysm</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4d.</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-21-61</u> to <u>3-25-61</u> , that (I) (we) last saw the deceased alive on <u>3-24-61</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Abraham W. Danish</u>		22b. DATE SIGNED <u>3-25-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		22d. ADDRESS <u>927 PERSHING DR SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/29/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u>		25a. REC'D BY REGISTRAR <u>1283 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Catharine S. Hance</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3240

03228

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 110 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH March 29 1961	
3. NAME OF DECEASED (Type or print) Calvin Hayes		4. MIDDLE COBB		5. SEX Male	
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-21-89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		9. AGE (In years, last birthday) 71 yrs.	
13. FATHER'S NAME George W. Cobb		14. MOTHER'S MAIDEN NAME Alberta Hayes		11. BIRTHPLACE (County & State, or foreign country) Maine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-34-3661		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pelvic Bone, and probably central nervous system metastases DUE TO (b) Carcinoma of the prostate DUE TO (c) Carcinoma of the prostate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year: 19 Hour a.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 9 1960 to March 29, 1961, that (X) (we) last saw the deceased alive on March 29, 1961, and that death occurred at 7:50 PM, from the causes and on the date stated above.					
22a. SIGNATURE H. S. IRONS, LT, MC, USN		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-30-61	
22c. PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
24. FUNERAL DIRECTOR'S SIGNATURE Gawlers Funeral Home, 1756 Pa. Ave., NW, WashDC		24b. ADDRESS Arlington		24c. LOCATION (City, town or county) (State) Virginia	
25a. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE William L. Hanna			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 03224

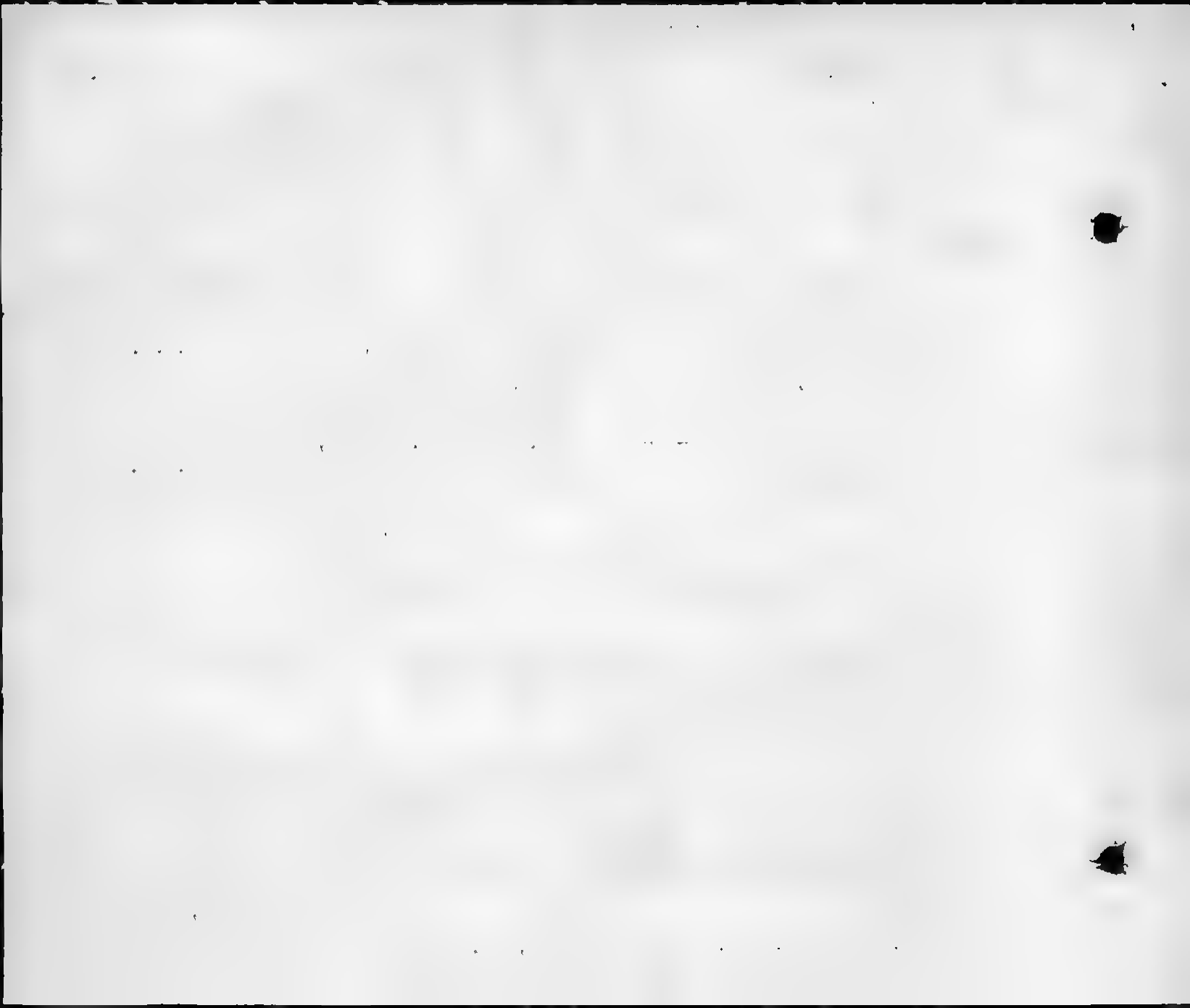
3241

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		e. STREET ADDRESS 3710 NIMITZ ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE LYLE COINER		4. DATE OF DEATH Month Day Year MARCH 14 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/82
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Express Clerk		10b. KIND OF BUSINESS OR INDUSTRY Seaboard Airline RR	
11. BIRTHPLACE (State or foreign country) Waynesboro, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Casper Coiner		14. MOTHER'S MAIDEN NAME Hannah Rebecca Coiner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 714-16-3346	
17. INFORMANT Mrs. Carrie L. Coiner, 9202 Sudbury Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Congestive Heart Failure (b) Anterior wall myocardial infarction (c) Senility INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/7/60, 19 to 3/14/1961, that I last saw the deceased alive on 3/14, 1961, and that death occurred at 12:25 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SAM ALLEN, M.D. Kensington, Maryland			
ACTUAL SIGNATURE SAM ALLEN M.D.		PHYSICIAN'S NAME (Type) SAM ALLEN M.D.	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/61	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond G. Jiska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE C. S. S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

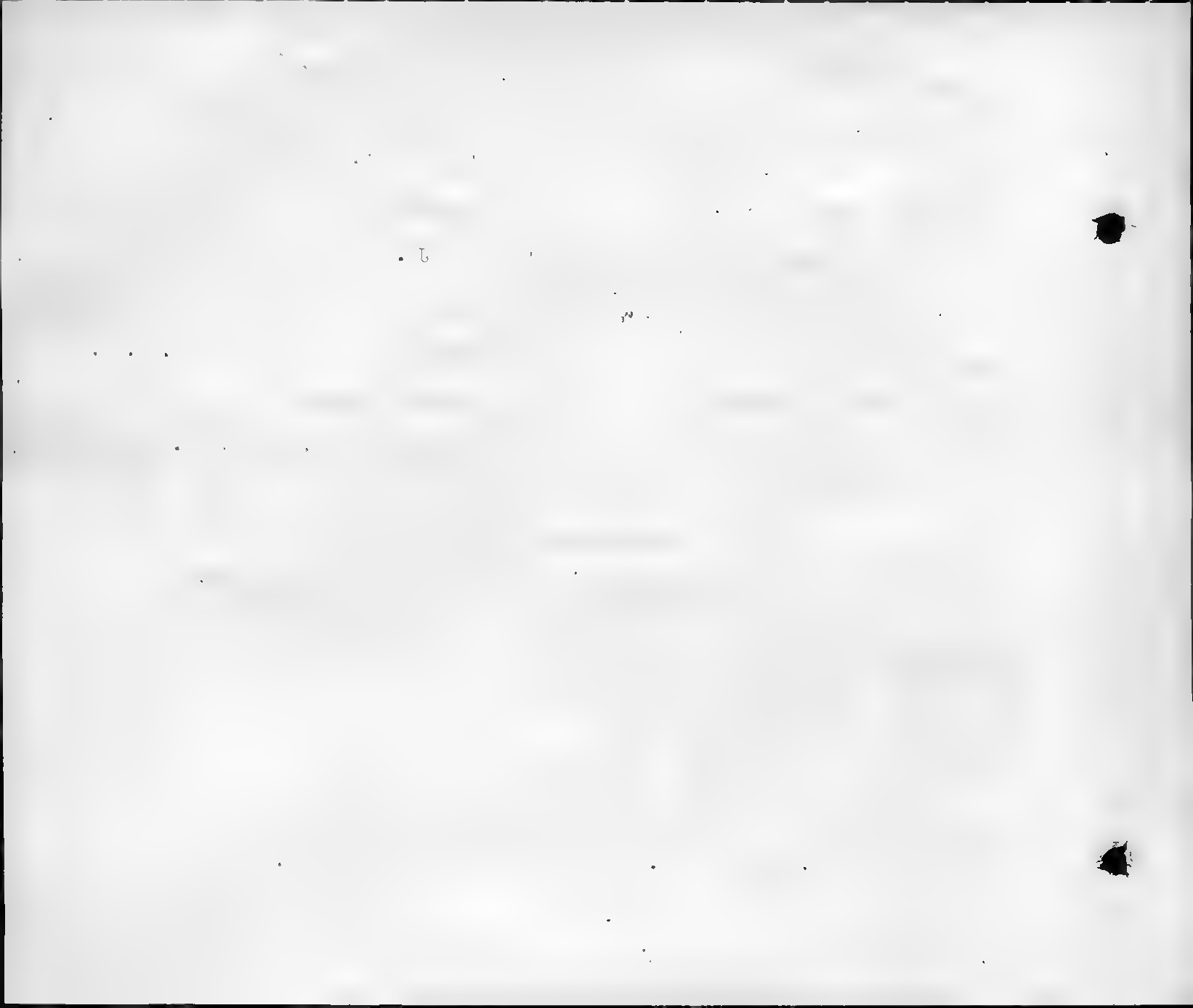


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3242  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03230

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES EARL COLBERT Jr.</b>		4. DATE OF DEATH Month Day Year <b>MARCH 12 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/12</b>
9. AGE (In years lost birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VIRGINIA</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES COLBERT</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Acute cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Extensive bilateral bronchial pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>48 hours</b> <b>10 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/3/ 9:50 p</b> <b>3/12/ 1961</b> , that (I) (we) last saw the deceased alive on <b>3/12/ 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles S. Whitaker</b>		22b. DATE SIGNED <b>3/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M. D.</b>		22d. ADDRESS <b>CLARKSVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		23d. LOCATION (City, town, or county) (State) <b>Clarks ville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C.Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3243

## CERTIFICATE OF DEATH

Reg. Dist. No.

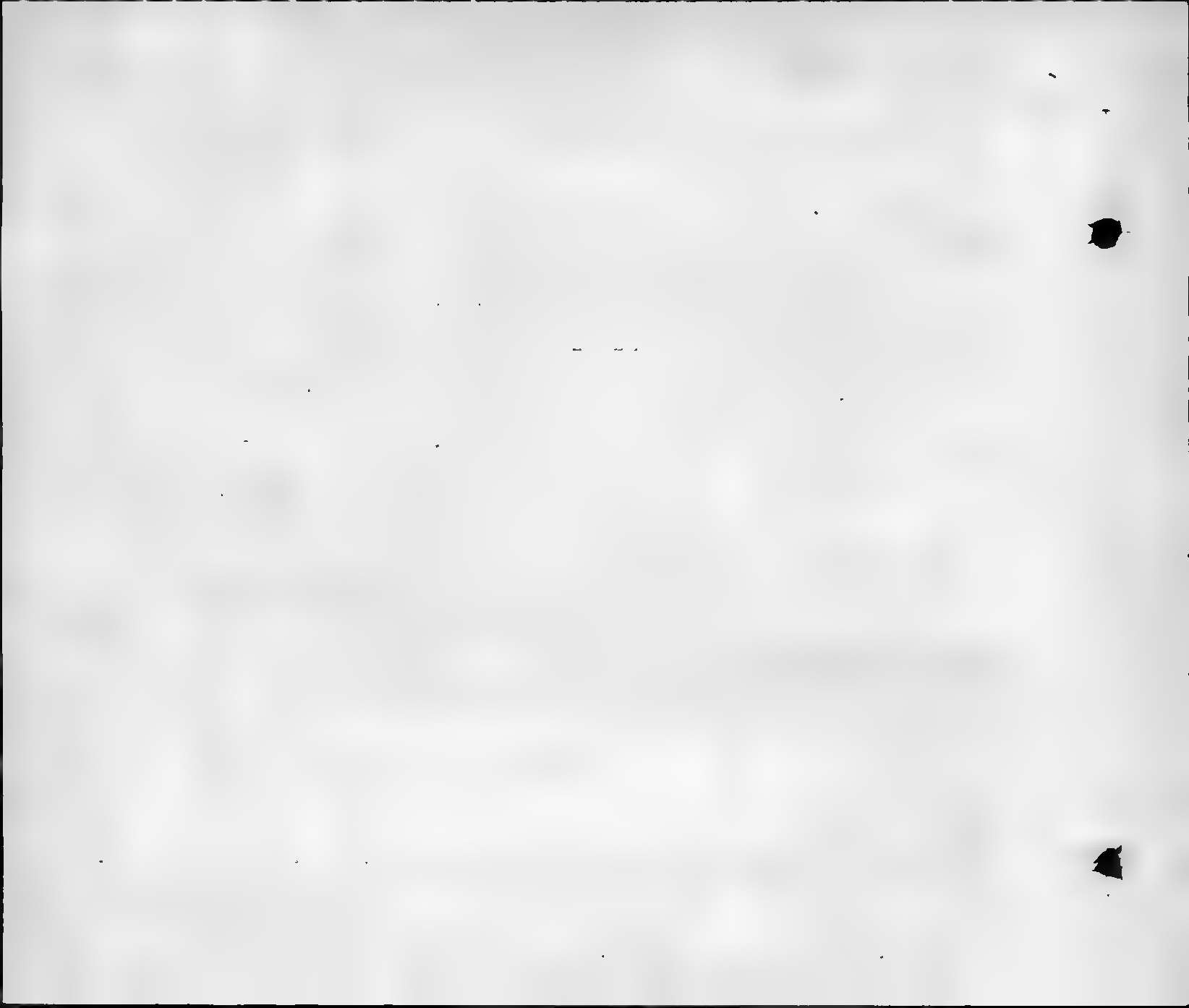
03231

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>488 Bethesda</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4858 Battery Lane</b>			d. STREET ADDRESS <b>4858 Battery Lane</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Alice Cramer</b>			4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1881</b>		9. AGE (In years last birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Winfield S. Epler</b>			14. MOTHER'S MAIDEN NAME <b>Mary Cunningham</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>William E. Cramer, Jr.--Son-Bethesda, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Crownary heart disease, congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Feb 15, 1961</b> to <b>March 4, 1961</b> , that I last saw the deceased alive on <b>March 3, 1961</b> , and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6450 Wisconsin Ave Bethesda, Md.</b> DATE SIGNED <b>3/4/61</b>					
ACTUAL SIGNATURE <b>Dr Joseph Kenrick</b> M.D.					
PHYSICIAN'S NAME (Type) <b>DR JOSEPH KENRICK</b>			6450 Wisc. Ave. Bethesda, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>			ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 8 '61</b>
24b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

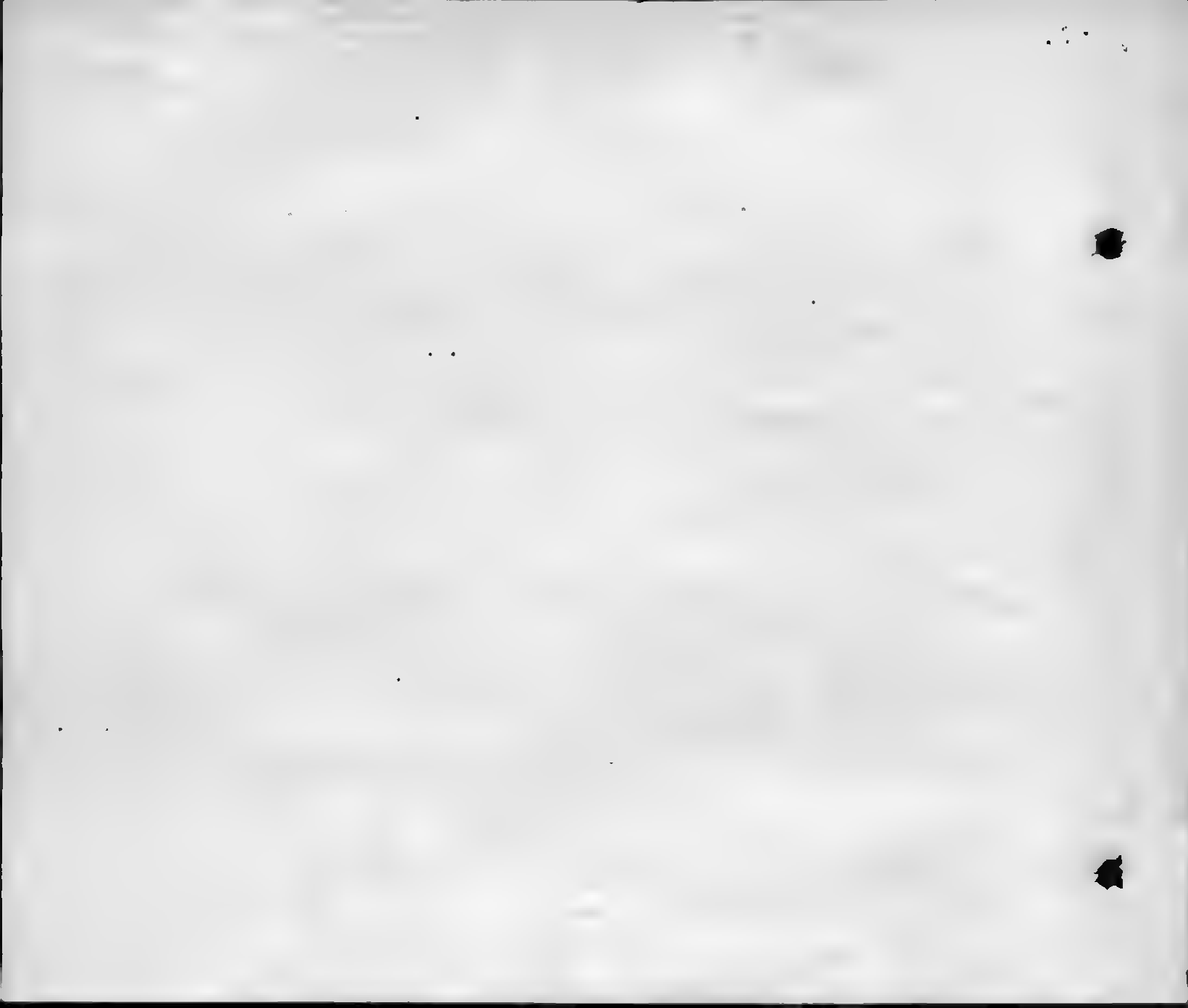
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Arthur S. France



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**32 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

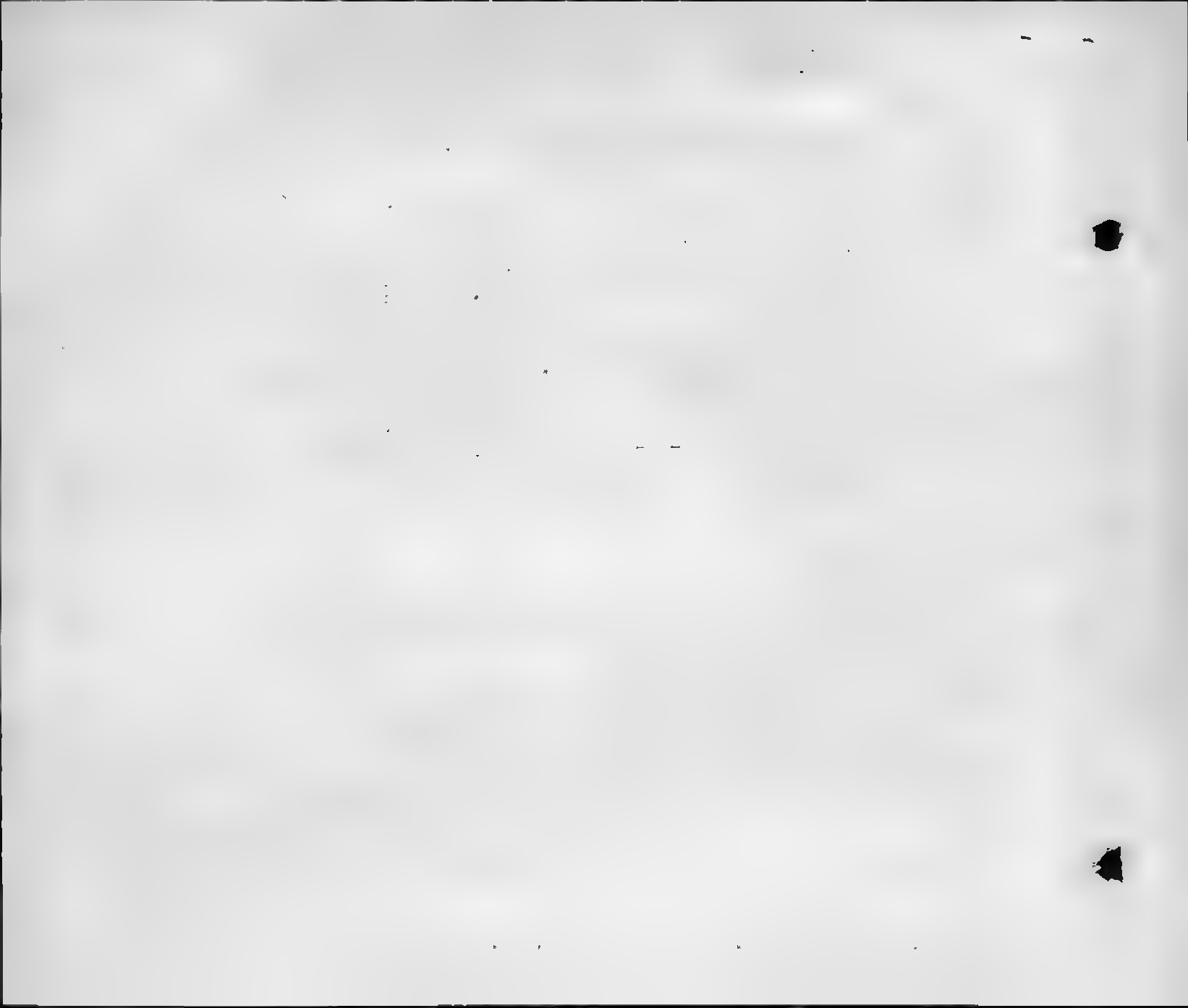
03203

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN It <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN + Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> COUNTY <u>PR. Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> d. STREET ADDRESS <u>1420 East West Hwy</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Walker Dalton</u>		4. DATE OF DEATH <u>3 15 19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Edward Dalton</u>		14. MOTHER'S MAIDEN NAME <u>Georgie Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>265-01-9543</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>LEFT CORONARY SCLEROSIS, SEVERE</u> DUE TO (c) <u>RIGHT CORONARY OCCLUSION, OLD</u> ASPIRATION OF STOMACH CONTENT PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>YEARS</u> <u>1 HOUR</u>	
20a. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>3-16-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Fredericksburg, Virginia</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 20 61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
5M 7/59



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

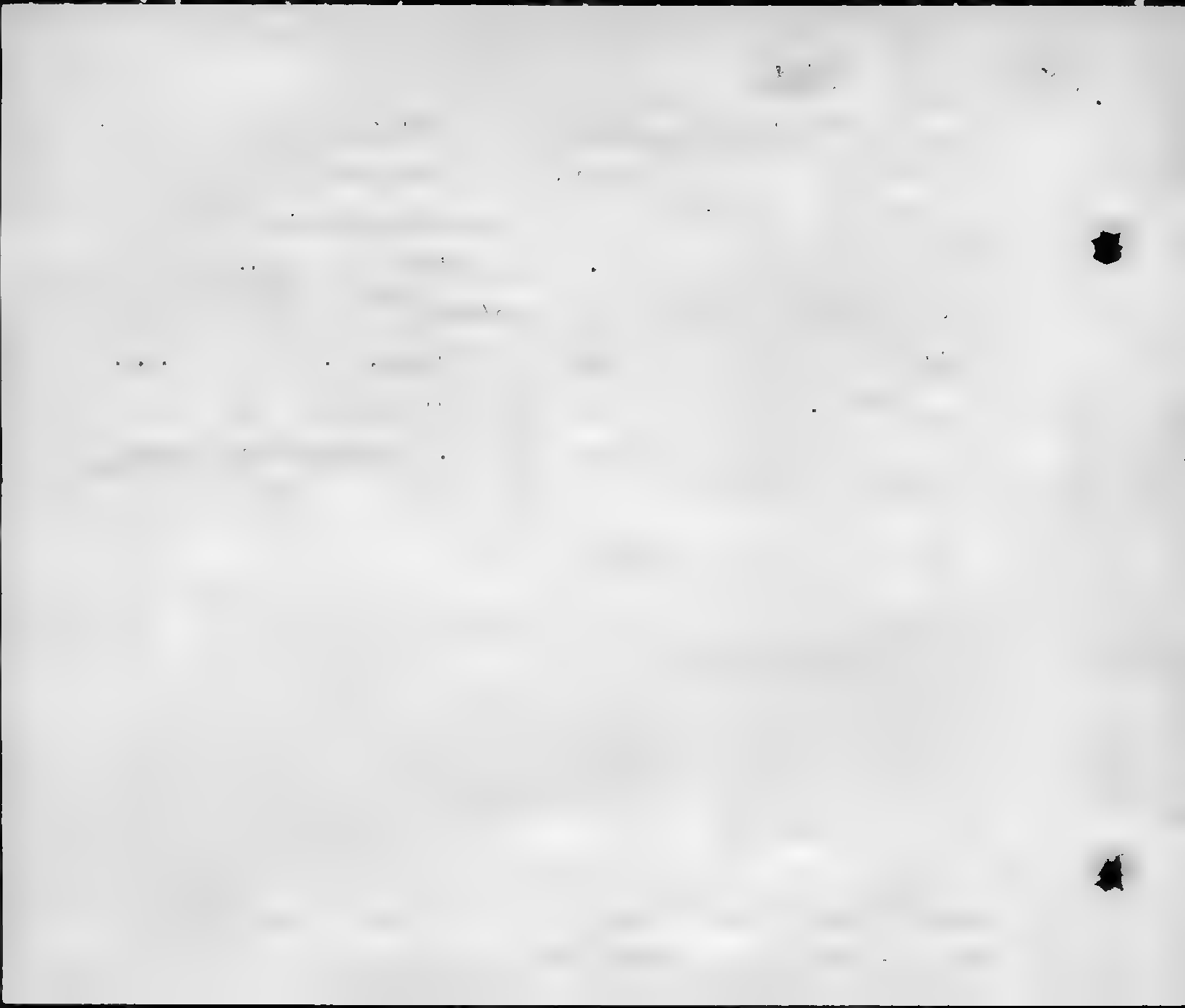
## CERTIFICATE OF DEATH

3246

03234

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
c. LENGTH OF STAY IN 1b <b>22 hrs.</b>		d. STREET ADDRESS <b>10204 Oldfield Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy L. Davies</b>	4. DATE OF DEATH <b>March 18 19 61</b>	5. SEX <b>Male</b> 6. CO. OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>2/24/99 1899</b>	9. AGE (in years last birthday) <b>62</b> yrs. 10. MONTHS <b>1</b> 11. DAYS <b>16</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
13. FATHER'S NAME <b>Thomas G. Davies</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Wife Mrs. Ruth Davies</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA LIVER</b> DUE TO <b>And OMENTUM, ESOPHAGUS.</b> (b) <b>PRIMARY CARCINOMA - STOMACH.</b> (c) <b>STOMACH.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of 13m 1)	
20c. TIME OF INJURY Month Day, Year <b>19</b>	20d. INJURY OCCURRED <b>While at work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/2/57</b> , 19 <b>57</b> , to <b>3/18/61</b> , 19 <b>61</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>3/17/61</b> , 19 <b>61</b> , and that death occurred at <b>...</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. BLAINE FITZGERALD</b>	22d. ADDRESS <b>8218 WISCONSIN AVE. BETHESDA.</b>		
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial-Transit 3/20/61</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Moscow Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Moscow, Pennsylvania</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		25a. REC'D BY REGISTRAR <b>...</b> 25b. REGISTRAR'S SIGNATURE <b>...</b>	
25c. ADDRESS <b>Bethesda, Maryland</b>		DATE <b>MAR 21 '61</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon 4 and file it with the State Dept. of Health.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3247

CERTIFICATE OF DEATH

Reg. Dist. No. 03235

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
c. LENGTH OF STAY IN 1b <b>20 yrs.</b>				d. STREET ADDRESS <b>6221 Tilden Lane</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>L</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1891</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Myrtle V. Davis</b> Address <b>3221 Tilden Lane., Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary heart disease c hypertension</b> DUE TO (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>20 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 28, 19 55</b> to <b>10 Mar., 19 61</b> that I last saw the deceased alive on <b>7 Mar., 19 61</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7801 Norfolk Avenue</b> DATE SIGNED <b>3/15/61</b>							
ACTUAL SIGNATURE <i>John M. Wyman</i>			M.D. <b>7801 Norfolk Avenue</b> <b>3/15/61</b>				
PHYSICIAN'S NAME (Type) <b>John M. Wyman, M. D.</b>			<b>Bethesda, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove.</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Zion, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>Charles E. Kneass</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

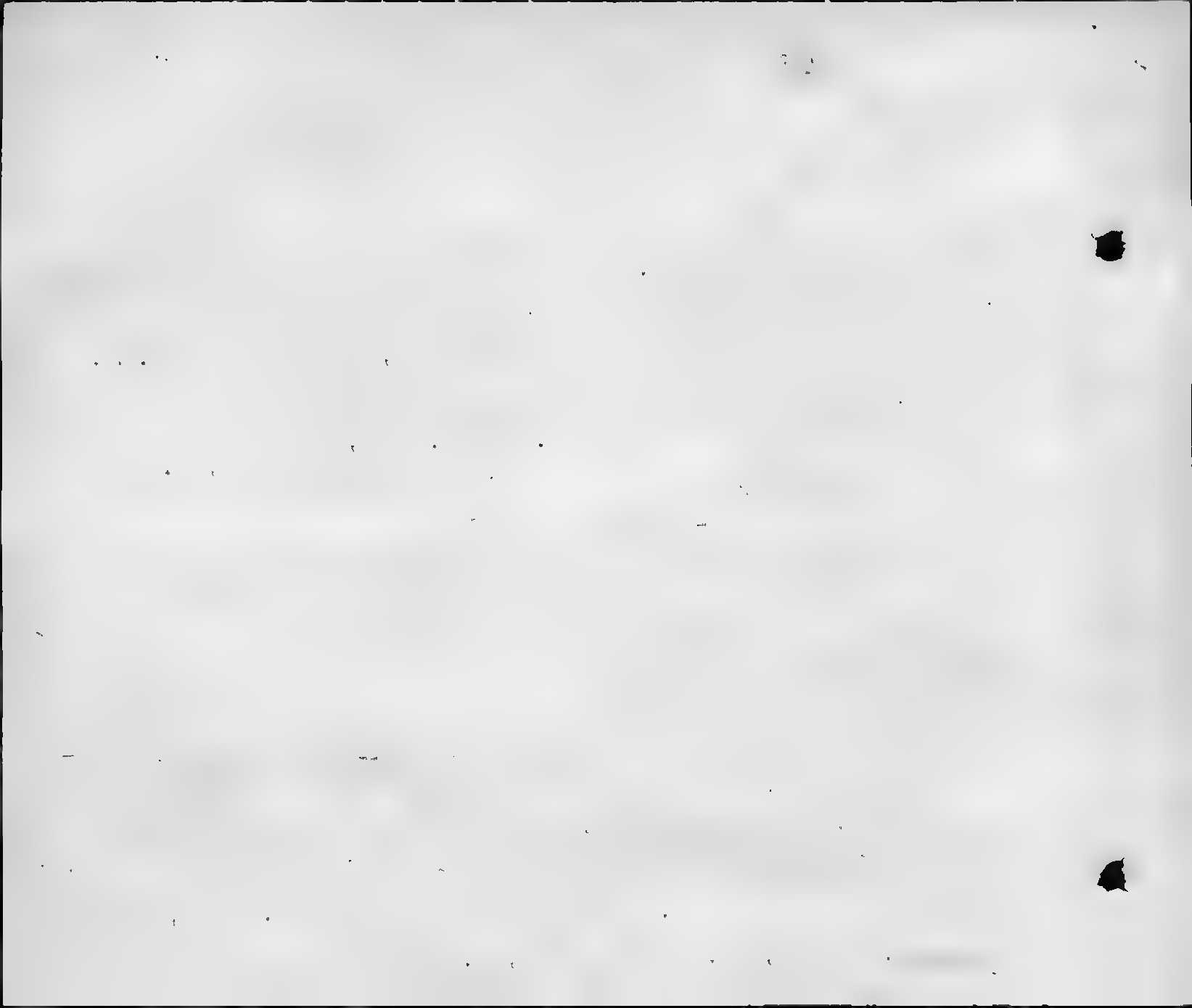
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

3248

03236

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY (in days) <b>1 year</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>721 DALE DRIVE</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>721 DALE DRIVE</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ELSIE C. DAVIS</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>MARCH 27 19 61</b> Month Day Year	
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>7/27/73</b>	
<b>9. AGE</b> (in years last birthday) <b>87</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BURLINGTON, IOWA</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE P. CARPENTER</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	
<b>17. INFORMANT</b> <b>Mr. Edwin C. Davis, 721 Dale Drive</b> Address		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sclerosing Carcinoma, Right Breast</b> (b) <b>Metastases to Dorsal Spine</b> (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <b>Diabetes Mellitus</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Silver Spring, Md.</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from April 25, 1960, to March 27, 1961, that (I) (we) last saw the deceased alive on March 25, 1961, and that death occurred at 1:15 PM, from the causes and on the date stated above.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>22a. SIGNATURE</b> <b>Merrill M. Cross M.D.</b>		<b>22b. DATE SIGNED</b> <b>3/27/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>MERRILL M. CROSS M.D.</b>		<b>22d. ADDRESS</b> <b>8248 GEORGIA AVE SILVER SPRING MARYLAND</b>	
<b>23a. BURIAL, CREMATION REMOVAL</b> (Specify) <b>CREMATION</b>		<b>23b. DATE THEREOF</b> <b>3/27/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FT. LINCOLN CREMATORY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond E. Pumphrey, INC.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>3 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Kneass</b>		<b>25c. ADDRESS</b> <b>SILVER SPRING, MD.</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

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VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3249 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03237

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10705 Huntley Place</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Erie</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Erie</u> d. STREET ADDRESS <u>657 East 31 St.</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie Regina Davis</u>		4. DATE OF DEATH <u>Mar 28 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Humphrey</u>		14. MOTHER'S MAIDEN NAME <u>Susan Wise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Shirley Mahon - Sister</u>		Address <u>Erie, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>4/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ERIE, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>APR 3 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	



# 1 FOR STATE HEALTH DEPT.

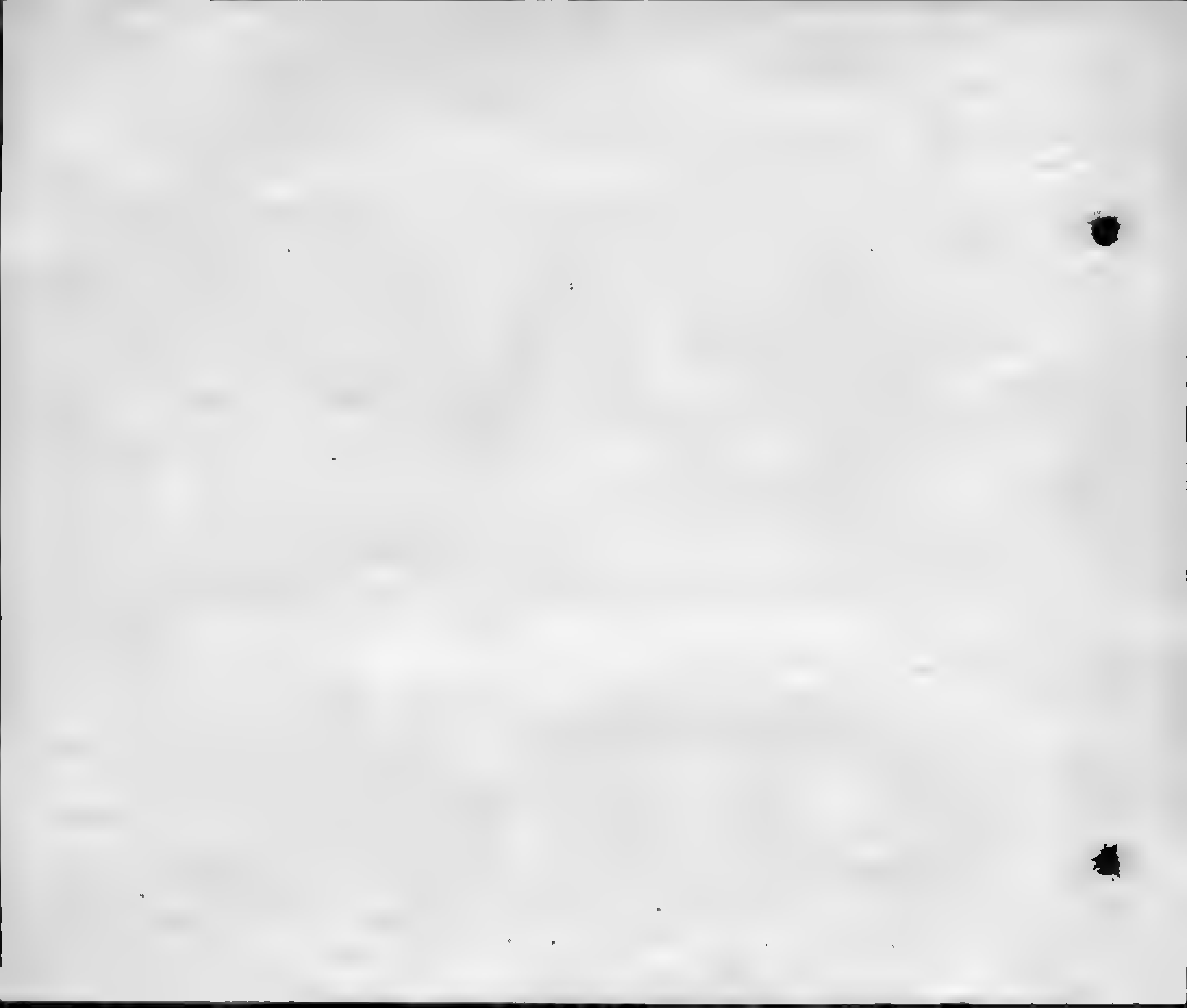
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03238											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN + Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1441 Spring Rd, NW</u> d. STREET ADDRESS <u>1441 Spring Rd, NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ROBERT Allan Davis</u>				4. DATE OF DEATH <u>3-12-61</u>				5. SEX <u>m</u>			
6. COLOR OR RACE <u>Cauc</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-12-42</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Usber -</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Theater</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>James Davis</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve Mayes</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Mother - Mrs Gene Davis</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Bullet wound in skull</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Blowing Russian Roulette + shot self in head</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Blowing Russian Roulette + shot self in head</u>											
20c. TIME OF INJURY Month, Day, Year <u>4:00 p.m. 3-9 1961</u> 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>11605 Bonifant Rd Silver Spring Md</u> 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-12-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/15/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Prince Georges Co. Md.</u>				22e. REC'D BY REGISTRAR <u>Arthur L. Hines</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			
23. FUNERAL DIRECTOR <u>The S.H. Hines Co. Washington, D. C.</u>											



# MARYLAND STATE DEPARTMENT OF HEALTH

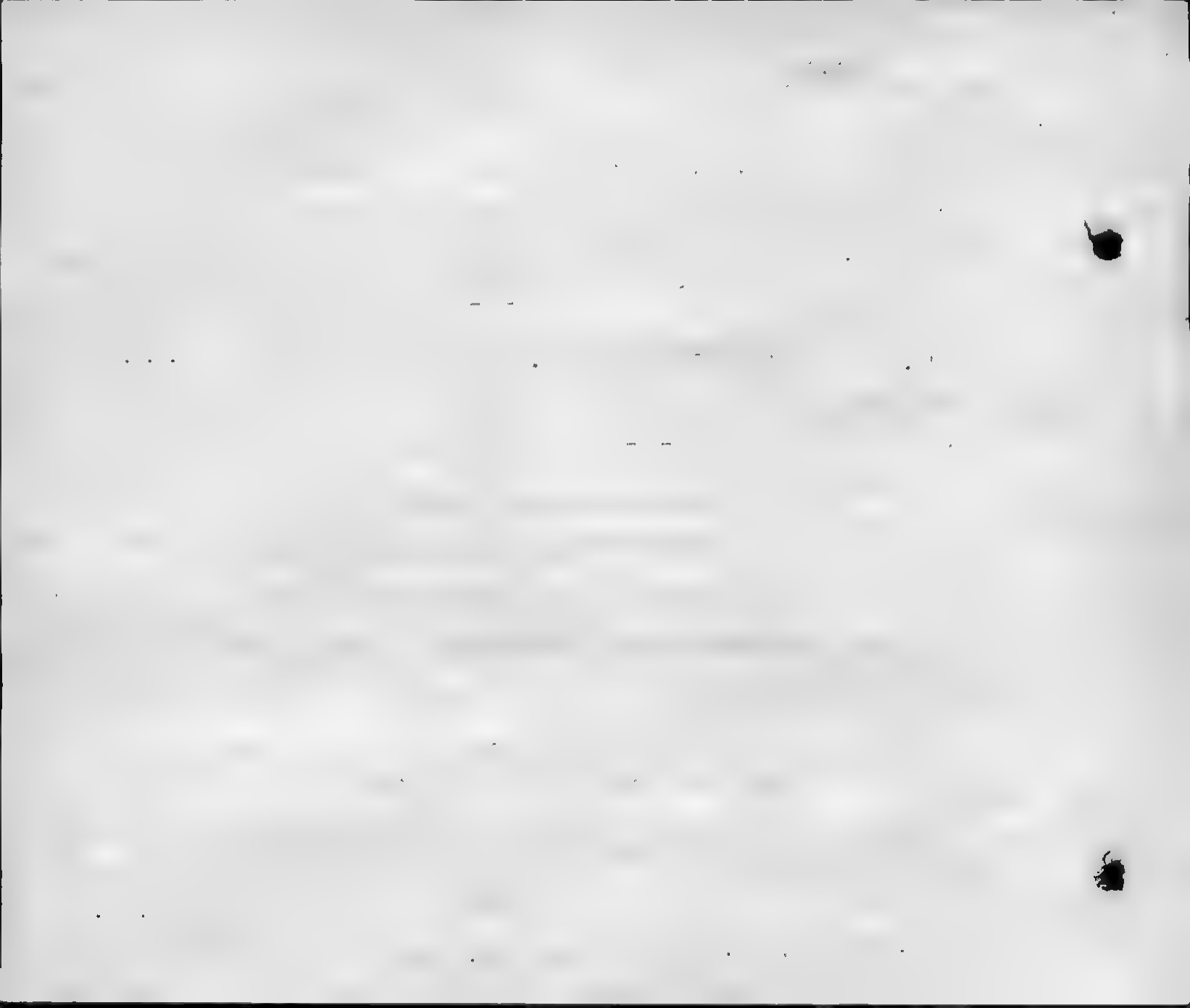
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3251

03289

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12, Md.</u> c. LENGTH OF STAY IN It <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>200 E. Franklin Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mrs. MAY LOUISE DAYTON</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>6</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-29-02</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired.) <u>Housewife</u>		<b>11. BIRTHPLACE</b> County & State or foreign country <u>District of Columbia</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Yulee Hodges</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Edith Keniston</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO</b> <u>578-03-2196</u>	
<b>17. INFORMANT</b> <u>Patients Chart</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Metastatic Carcinoma to lungs</u> DUE TO (c) <u>Adenocarcinoma of both breasts</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATING TO THE TERM N.A. DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic carcinoma to long &amp; short bones - pathological fracture of hip &amp; ribs</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury, Part I or end of line B)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2-24, 1947</u> to <u>3-6, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 6, 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above			
<b>22a. SIGNATURE</b> <u>Benjamin Isaacson, M.D.</u>		<b>22b. ADDRESS</b> <u>7733 Alaska Ave., N.W.</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Benjamin Isaacson, MD</u>		<b>22d. DATE SIGNED</b> <u>3/6/61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3/9/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CEMETERY</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		<b>25a. REC'D BY REG. STR.</b> <u>MAR 10 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. A. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3252

03240

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>910 Newhall Street</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>910 Newhall Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES EDWARD DELAMAISSON</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>26</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 11, 1888</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Same</u>	<b>9. AGE</b> In years last birthday <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Switzerland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Edward M. Delamaison</u>		<b>14. MOTHER'S MARRIED NAME</b> <u>Caroline Louise Ponnai</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>Mrs. Helen K. Delamaison (Same as #2)</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <u>Congestive Cardiac Failure</u> <u>Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Six Mos.</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. City or town</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 1957</u> <b>to</b> <u>March 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 26, 1961</u> , and that death occurred at <u>11:50 P.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Robert A. Hare</u>		<b>22b. DATE SIGNED</b> <u>March 27, 61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert A. Hare M.D.</u>		<b>22d. ADDRESS</b> <u>7600 Carroll Ave. T. Park, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>March 29, 1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Park Creek Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington D.C.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Hare</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 28 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hare</u>		<b>25c. DATE</b>	

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MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

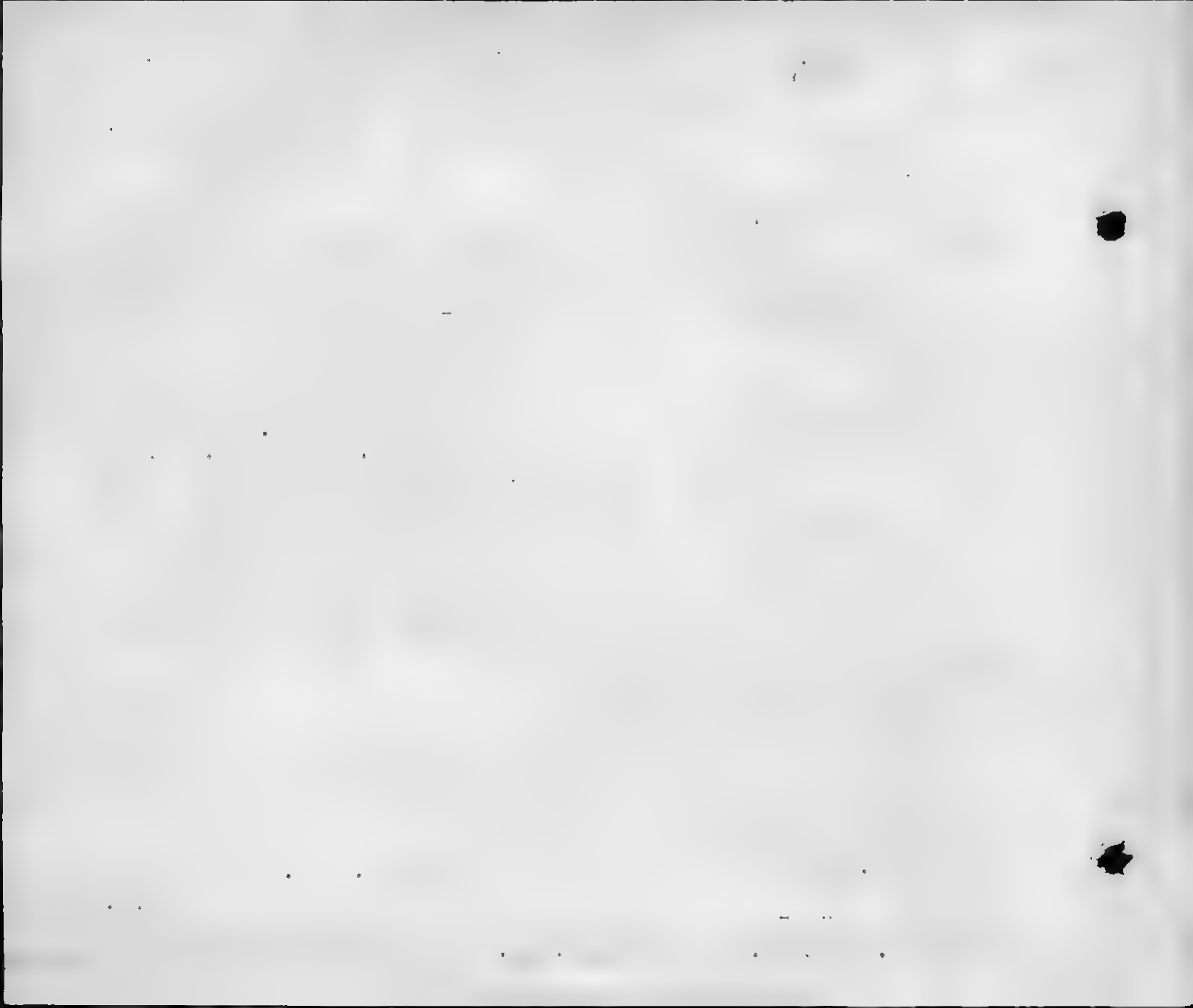
## CERTIFICATE OF DEATH

3253

03241

<b>1. PLACE OF DEATH.</b> a. COUNTY <u>Montg</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> c. LENGTH OF STAY IN b <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) <u>The Marylander Home of Rest</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Catherine</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec 18-1881</u> <b>9. AGE</b> (in years, last birthday) <u>79 yrs.</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ireland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>		<b>13. FATHER'S NAME</b> <u>John Groark</u> <b>14. MOTHER'S M maiden name</b> <u>Bridget McCormack</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>4221</u> <b>17. INFORMANT</b> <u>ary Derosia, Arlington, Va.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> DUE TO (b) <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4221</u> DUE TO (c) <u>4221</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. INJURY OCCURRED: 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. (City or town) (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 10, 1954</u> <b>to</b> <u>March 25, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 22, 1961</u> , <b>and that death occurred at</b> <u>4:55 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>James P. Kerr</u> <b>22b. PHYSICIAN'S NAME (Type)</b> <u>James P. Kerr</u>		<b>22c. DATE SIGNED</b> <u>March 24, 1961</u> <b>22d. ADDRESS</b> <u>Damascus, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3-29-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood</u> <b>23d. LOCATION (City, town or county)</b> <u>Watertown</u> (State) <u>N. Y.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ernest C. Gartner. Gaithersburg.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 28 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>	

VR A15 (4)  
15M 9/60



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

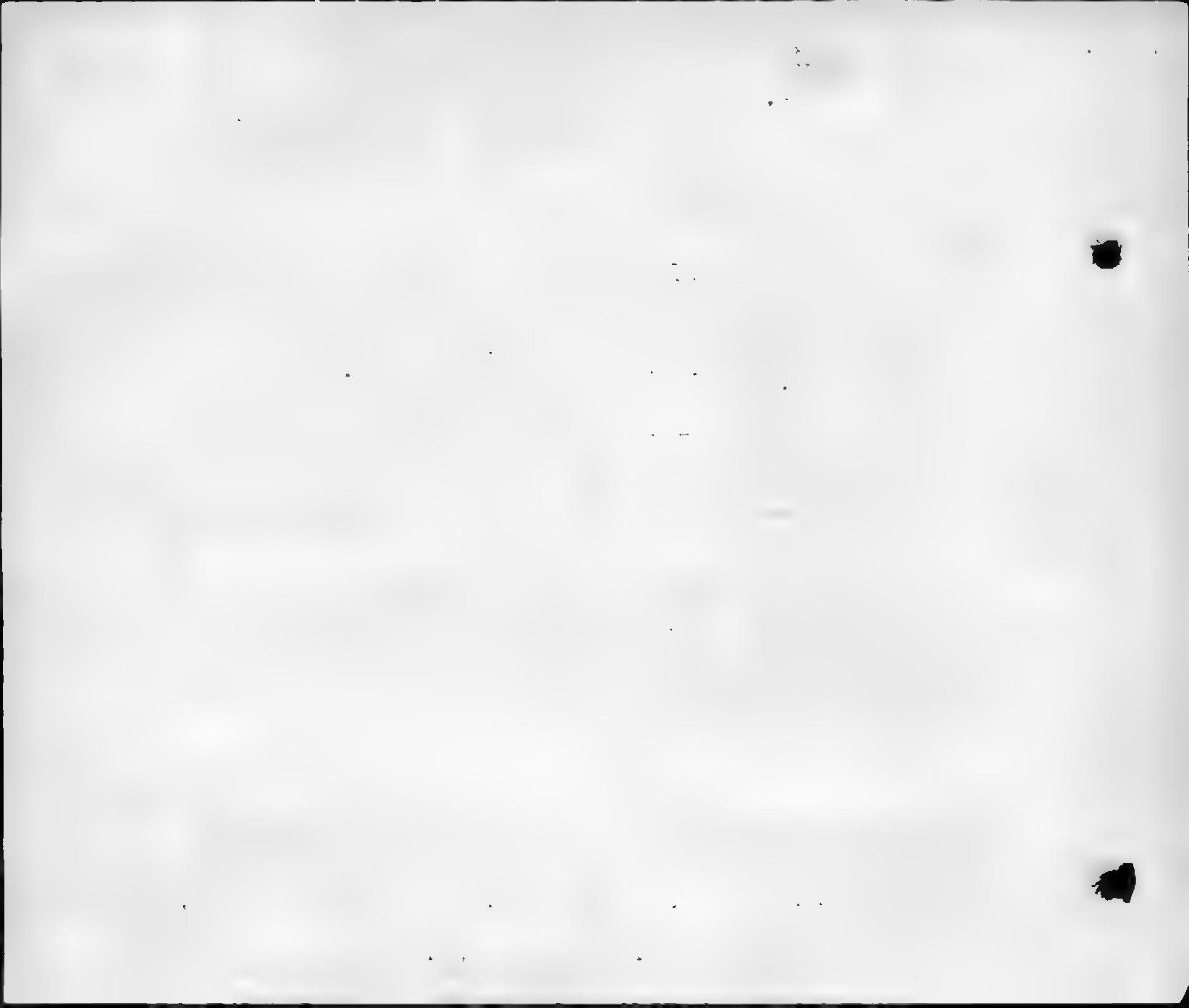
3254

03242

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>30 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>405 Thayer Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Frederick Edwin Dieste</b>				4 DATE OF DEATH Month Day Year <b>March 6 1961</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>white</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>November 2, 1904</b>	
9 AGE (In years lost birthday) <b>56 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min.		11 BIRTHPLACE (State or foreign country) <b>District of Columbia U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>WILLIAM F. DIESTE</b>				14 MOTHER'S MAIDEN NAME <b>Elizabeth Spengler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-09-3928</b>		17. INFORMANT Address <b>Washington Sanitarium and Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arricular Fibrillation &amp; Cardiac Failure</b> Condit ons, if any, wh gave rise to immed ate cause (a), stating the under ly'ng cause (s) <b>Chronic Cirrhosis of Liver</b> <b>Diabetes mellitus</b> <b>Chronic Nephritis &amp; Uremia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Oslea Arthritis, Bilateral hip joints</b>							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1960</b> to <b>Mar 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 5 1961</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above							
22a SIGNATURE <b>George L Ball</b>				22b DATE SIGNED <b>Mar 6, 1961</b>		22c PHYSICIAN'S NAME (Type) <b>George L Ball</b>	
22d ADDRESS <b>1629 Georgia Ave Silver Spring Md</b>				22e MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f ATTENDING PHYS <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>3/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William E. Humphrey, Inc.</b>				25a REC'D BY REGISTRAR <b>Mar 10 '61</b>		25b REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

(M)

(I)



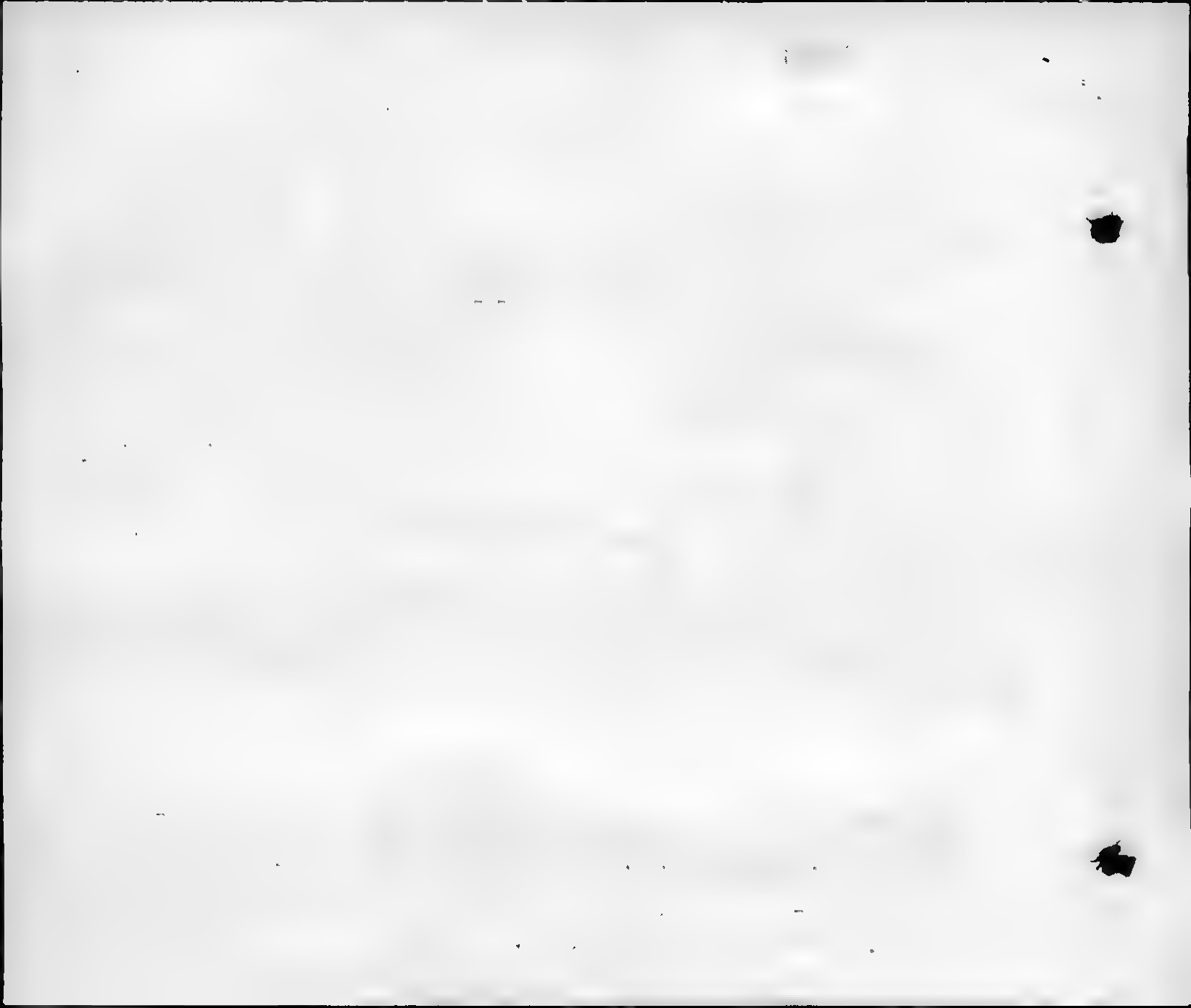
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3255

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03243

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
c. LENGTH OF STAY IN 1b <b>7 DAYS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>4818 DELRAY AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MACK</b> Middle <b>McCLINTON</b> Last <b>ECKENRODE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>31</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-4-1880</b>	9. AGE (In years last birthday) <b>80</b> yrs	IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>2</b>	IF UNDER 24 HRS Hours <b>2</b> Min.	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH ECKENRODE</b>				14. MOTHER'S MAIDEN NAME <b>ADA HONOR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Vermin</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 hr</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1955</b> to <b>March 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 31, 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3-31-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>				22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>S. P. K...</b>			





3256

## CERTIFICATE OF DEATH

Reg. Dist. No. 03244

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7504 Piney Branch Rd.</b>				d. STREET ADDRESS <b>7504 Piney Branch Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ELKAN</b> Last <b>ELKAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1895</b>	
9. AGE (In years lost birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>0</b>		11. IF UNDER 24 HRS Hours <b>5</b> Min <b>30</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>			
13. FATHER'S NAME <b>ABRAHAM ELKAN</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>Gerald Elkan - 7504 Piney Branch Rd., SA., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Leukemia, chronic (lymphatic)</b> 4-0 DUE TO (b) <b>4-0</b> DUE TO (c) <b>4-5 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July</b> , 19 <b>63</b> to <b>March 15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 13</b> , 19 <b>61</b> , and that death occurred at <b>5:30</b> A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>1801 Eye Street, N. W. Washington, D.C.</b>							
ACTUAL SIGNATURE <b>Alvin W. Eger</b> M.D.				1801 Eye Street, N. W. Washington, D.C.			
PHYSICIAN'S NAME (Type) <b>ALVIN W. EGER</b>				Washington, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Capital Hebrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons-3501 14th St., NW</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

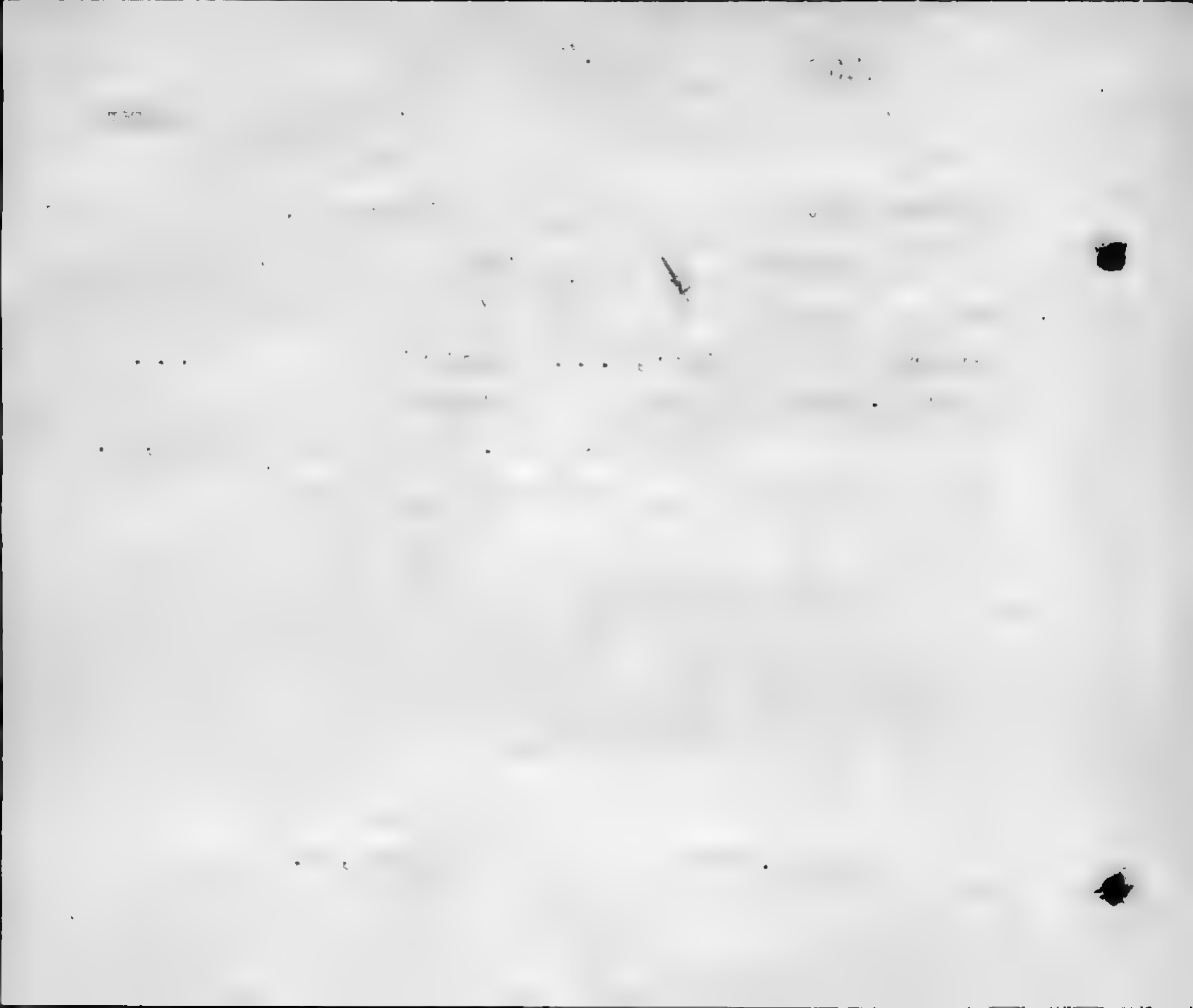
10

2-10-10

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO THE GENERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

3257												Item 9 Film 6282 3/9/61 mb												03245																																																																																			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>												b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>												c. LENGTH OF STAY IN 1b												d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>																																																																							
3. NAME OF DECEASED (Type or print) <b>Dorothy</b>												5. SEX <b>Female</b>												6. COLOR OR RACE <b>White</b>												7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <b>Ellis</b> <b>3/3/05</b>												9. AGE (in years last birthday) <b>56 5/11</b> yrs.												10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>												11. BIRTH-PLACE (County & State, or foreign country) <b>California</b>												12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Harry St. George</b>												14. MOTHER'S MAIDEN NAME <b>Ora Hood</b>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>												16. SOCIAL SECURITY NO. <b>556-010343</b>												17. INFORMANT <b>Mrs. Elizabeth Tallon</b>												Address <b>Rockville, Md.</b>																																															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b> DUE TO <b>Proliferative Endometrium</b> Conditions, if any, which gave rise to immediate cause (b) <b>metastatic ca. to lung</b> (a), stating the underlying cause last. DUE TO <b>Carcinoma of breast</b> (c) <b>2 yrs.</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>																																																																																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)												20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)																																															
21. I certify that (I) (this hospital) attended the deceased from <b>2/3/1958</b> to <b>3/4/1961</b> , that (I) (we) last saw the deceased alive on <b>3/4/1961</b> and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.												22a. SIGNATURE <b>Stephen N. Jones</b>												22b. DATE SIGNED <b>3/4/61</b>												22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>												22d. ADDRESS <b>Rockville, Md.</b>																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>												23b. DATE THEREOF <b>3-6-61</b>												23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>												23d. LOCATION (City, town or county) (State) <b>SUITLAND MD.</b>																																																																							
24. FUNERAL DIRECTOR'S SIGNATURE <b>BL Langansky</b>												24a. REC'D BY REGISTRAR <b>MAR 7 '61</b>												24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kneiss</b>												24c. ADDRESS <b>3501 14th St. NW</b>																																																																							



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3258

## CERTIFICATE OF DEATH

Reg. Dist. No. 03246

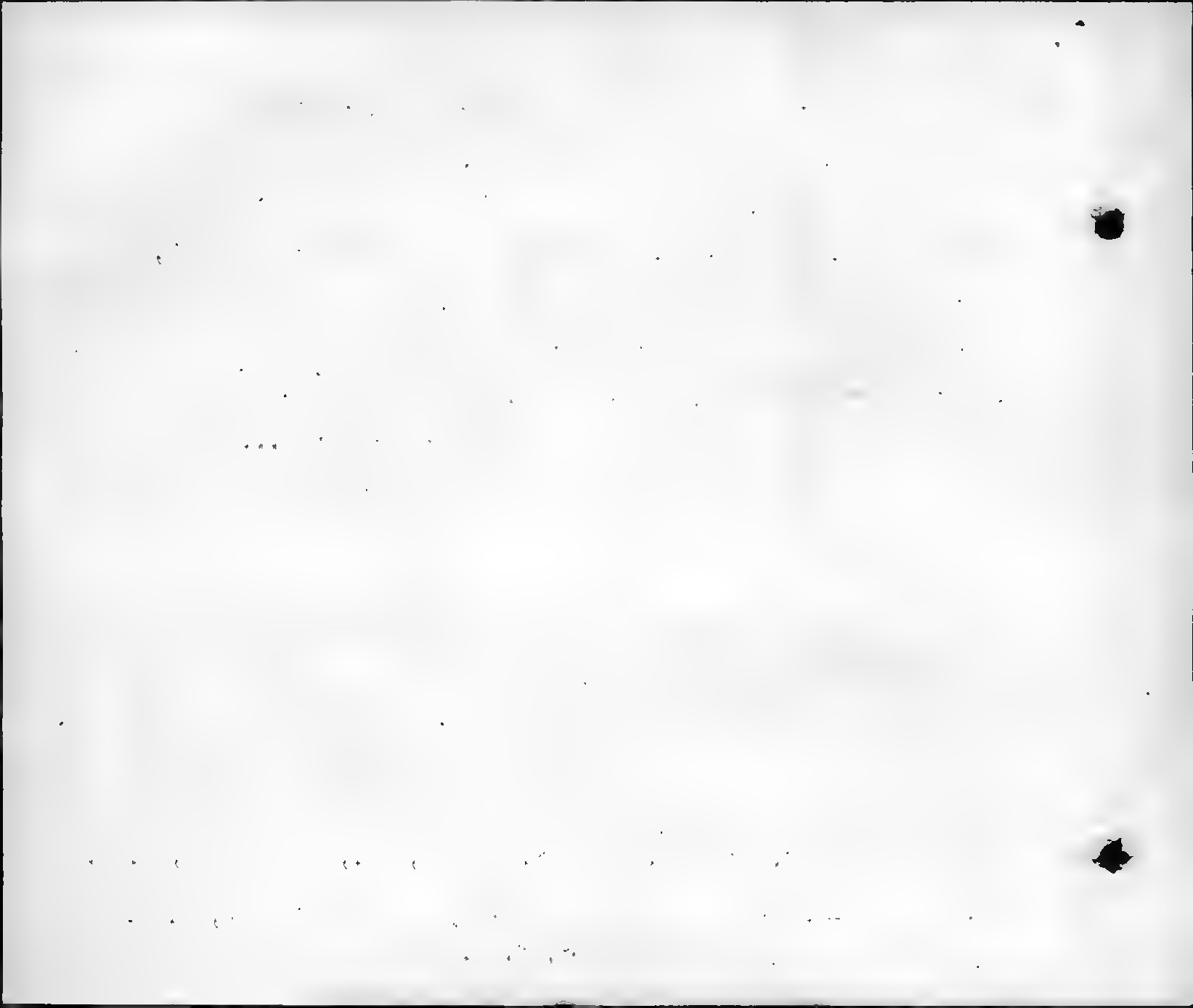
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> c. STREET ADDRESS <b>1112 16TH ST. NW</b> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LAURIE</b> Last <b>EVANS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES R. TARNER</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE LOUISE ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Sanitarium Records...</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Secretarial Arteriosclerosis</b> DUE TO (b) <b>Secretarial Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>2 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture R.H. Hip - Jan Jan 1961</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fall</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>Jan 1961</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Resmor San.</b>		20f. (City or town) <b>Washington, D.C.</b> (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , 19, to <b>3-5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3-5</b> , 19 <b>61</b> , and that death occurred at <b>3:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Geo. R. Huffman</b> M.D.		ADDRESS (Street, city or town, state) <b>1912 R. St. NW, D.C.</b> DATE SIGNED <b>3/5/61</b>	
PHYSICIAN'S NAME (Type) <b>George R. Huffman</b>		<b>1912 R. Street, NW., Washington, D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-8-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley Sons</b>		ADDRESS <b>Washington, D. C.</b>	
24a. REC'D BY REGISTRAR <b>MAR 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

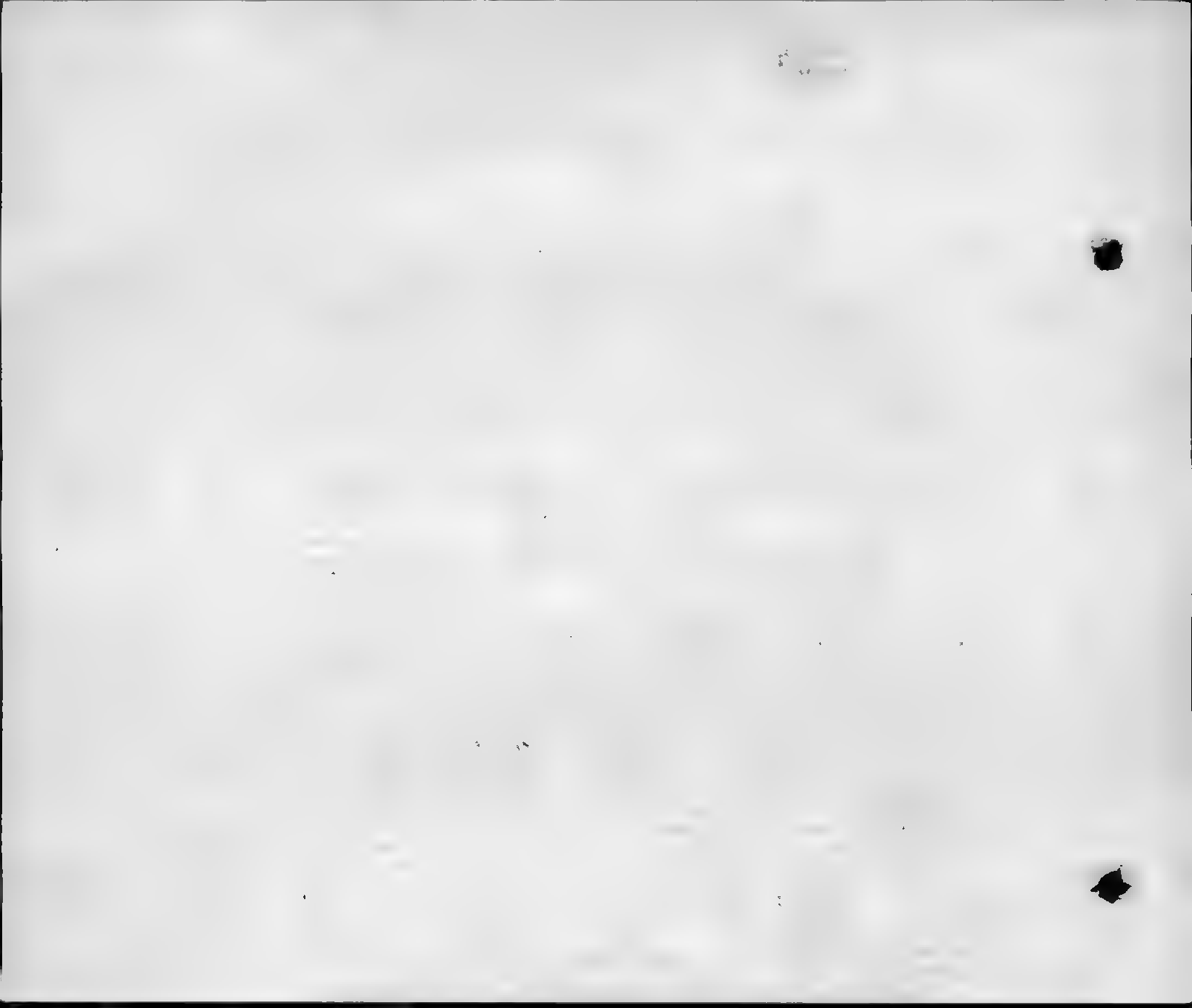
# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 3259 CERTIFICATE OF DEATH

03247

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN IT <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if not before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8515 Flower Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bessie IDA Everdale</u>		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>5</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>4-23-90</u> <b>9. AGE</b> (In years last birthday) <u>30</u> yrs IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Germany</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Germany</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Amer.</u>					
<b>13. FATHER'S NAME</b> <u>Theodore Schumm</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Primer</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>Chart - Washington Sanatorium &amp; Hospital</u>			
<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO (b) <u>arteriosclerotic heart disease &amp; congestive failure</u> (c) <u>  </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus E</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>3/4/1961</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>Laurel</u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3/1/1961</u> to <u>3/5/1961</u> , that (I) (we) last saw the deceased alive on <u>3/4/1961</u> , and that death occurred at <u>4:40</u> A.M. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>HUGH IREY</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>HUGH IREY</u>				<b>22b. DATE SIGNED</b> <u>3/5/1961</u> <b>22d. ADDRESS</b> <u>7105 Rogers Rd. Laurel, Md.</u>			
<b>23a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Mar 8 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>H. Lincoln Cemetery</u> <b>23d. LOCATION</b> (City, town, or county) <u>Prince George's Md.</u> (State) <u>  </u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>  </u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>MAR 7 '61</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/60

3260

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03248

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)  
c. LENGTH OF STAY IN 1b 1 hr. 20 min.  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 4927 Jamestown Road  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
First Victor Middle Oris Last FEIK

4. DATE OF DEATH  
Month March Day 18 Year 19 61

5. SEX Male  
6. COLOR OR RACE Caucasian  
7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH 3-14-98  
9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restauranteur  
10b. KIND OF BUSINESS OR INDUSTRY Retired  
11. BIRTHPLACE (County & State, or foreign country) Ohio  
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Christian FEIK  
14. MOTHER'S MAIDEN NAME Elizabeth LAUER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐ (If yes give year or dates of service)  
16. SOCIAL SECURITY NO.                       
17. INFORMANT                      Address                     

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Myocardial infarction  
DUE TO  
Conditions, if any, which gave rise to immediate cause (b) arterio-sclerotic heart disease  
DUE TO  
cause last (c)                     

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
                    

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.                       
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (~~has expired~~) attended the deceased from March 17, 1961, 12:21AM to March 18, 1961, that (I) (~~was~~) last saw the deceased alive on March 18, 1961 and that death occurred at                      from the causes and on the date stated above.

22a. SIGNATURE Vernon N. Houk  
22c. PHYSICIAN'S NAME (Type) Vernon N. HOUK, LT, MC, USN  
22b. DATE SIGNED 3-18-61  
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐  
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment  
23b. DATE THEREOF 3-19-61  
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Park  
23d. LOCATION (City, town or county) (State) Sharon, Mercer Co., Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey  
ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.  
25a. REC'D BY REGISTRAR DATE MAR 21 '61  
25b. REGISTRAR'S SIGNATURE Arthur S. Hines

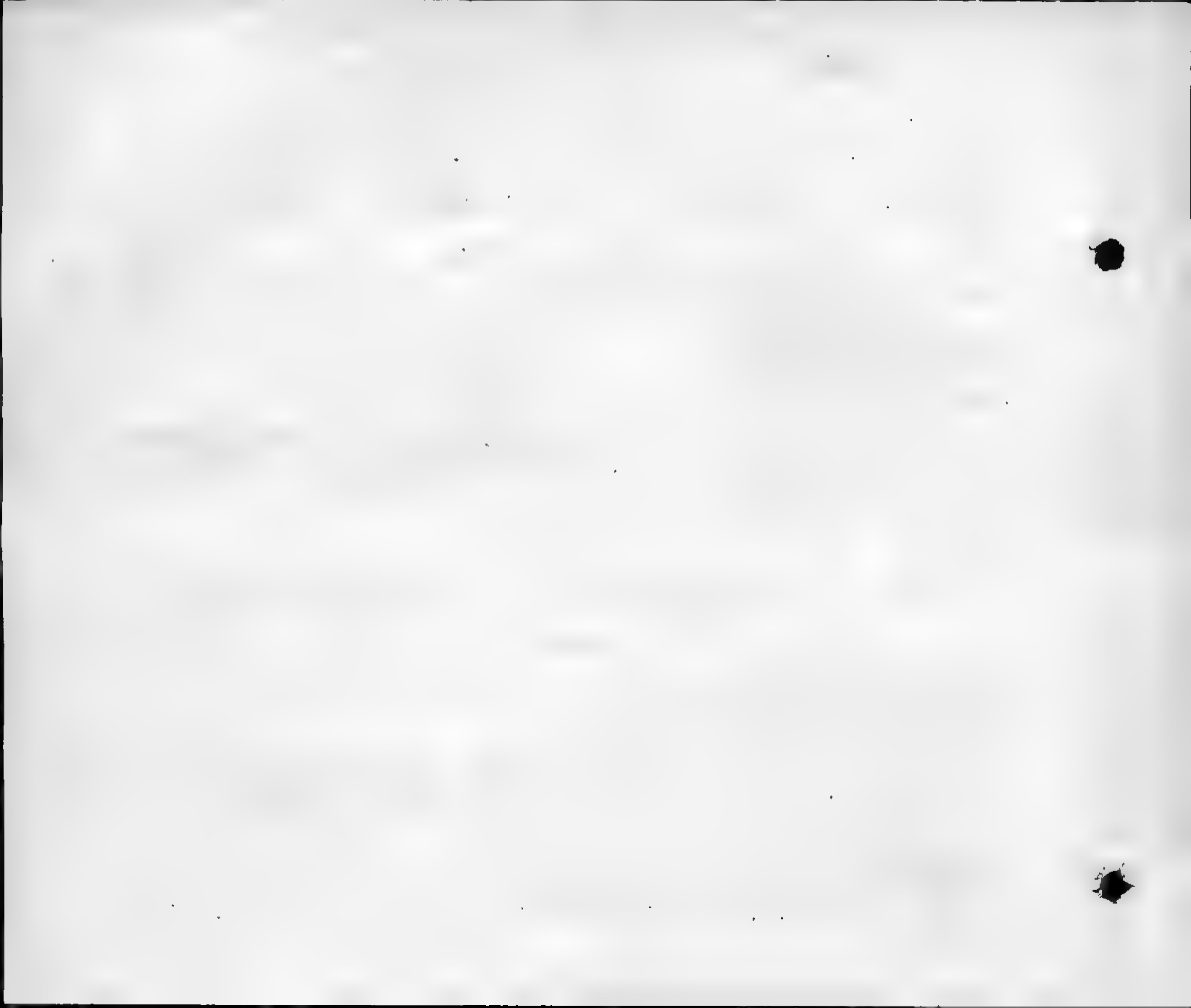


may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3261  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03249

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Va.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Vienna</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>				d. STREET ADDRESS <i>244 Maple E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lewis</i> Middle <i>Benton</i> Last <i>Flohr</i>				4. DATE OF DEATH Month <i>3</i> - Day <i>19</i> - Year <i>1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-20-73</i>		9. AGE (In years last birthday) <i>87</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Govt. employee</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John R. Flohr</i>				14. MOTHER'S MAIDEN NAME <i>Mary G. Green</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Washington San &amp; Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>Atherosclerotic Heart Disease &amp; Myocardial Fibrillation</i> DUE TO (c)							<i>4 Days</i> <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral Bronchopneumonia</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>3-15</i> 1961, to <i>3-19</i> 1961, that (I) (we) last saw the deceased alive on <i>3-19</i> 1961, and that death occurred at <i>2:05 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Shirley Nelson</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 23, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>Falls Church, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Chen Davis</i> ADDRESS <i>Vienna, Va.</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 21 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony S. Kraus</i>	

I



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

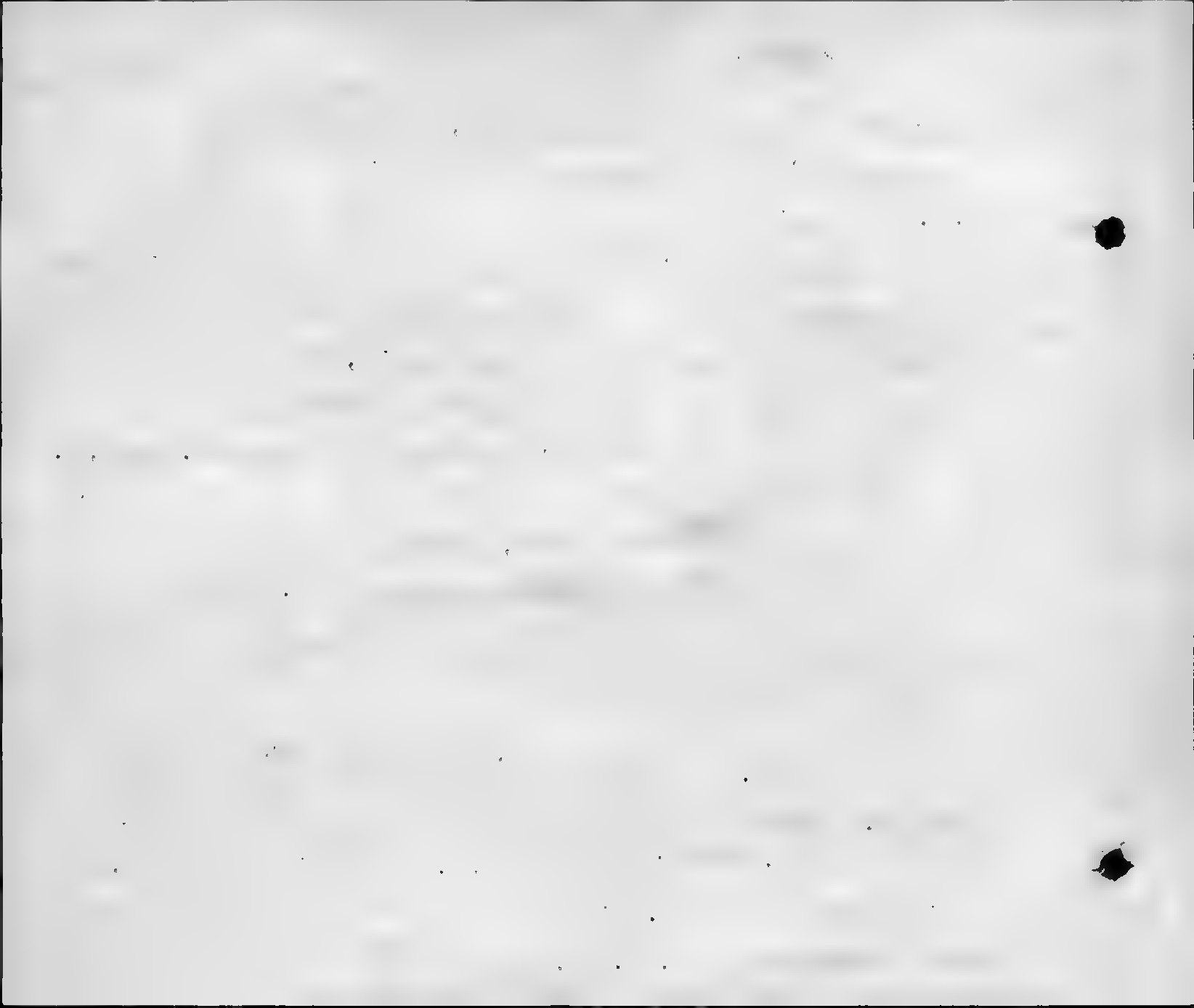
3262

## CERTIFICATE OF DEATH

03250

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>UTAH,</b>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 DATE OF DEATH <b>March 11 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 August 1918</b>		9. AGE (In years last birthday) <b>42</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>		11. BIRTHPLACE County & State, or foreign country <b>Salt Lake City, UTAH</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Nick FLOOR</b>		14. MOTHER'S MAIDEN NAME <b>Catherine GIANICOPOULOS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mary "Z" FLOOR 5705 Wrightson Dr. McLean, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO <b>UNKNOWN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RHEUMATIC VALVULITIS, INACTIVE</b> (c) <b>AORTIC STENOSIS AND INSUFFICIENCY.</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>Mar. 5 1961</b> to <b>Mar. 11 1961</b> , that <b>(A)</b> (we) last saw the deceased alive on <b>Feb. 11 1961</b> , and that death occurred at <b>1036 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Joseph E. Stitches</b> 22b. PHYSICIAN'S NAME (Type) <b>Joseph E. Stitches LT, MC, USN</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Burial-Shipment 3-11-61 Mt. Olivet</b>		22d. LOCATION (City, town or county) (State) <b>Salt Lake City Utah</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>		22b. DATE SIGNED <b>3-11-61</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>Burial-Shipment 3-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Salt Lake City Utah</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

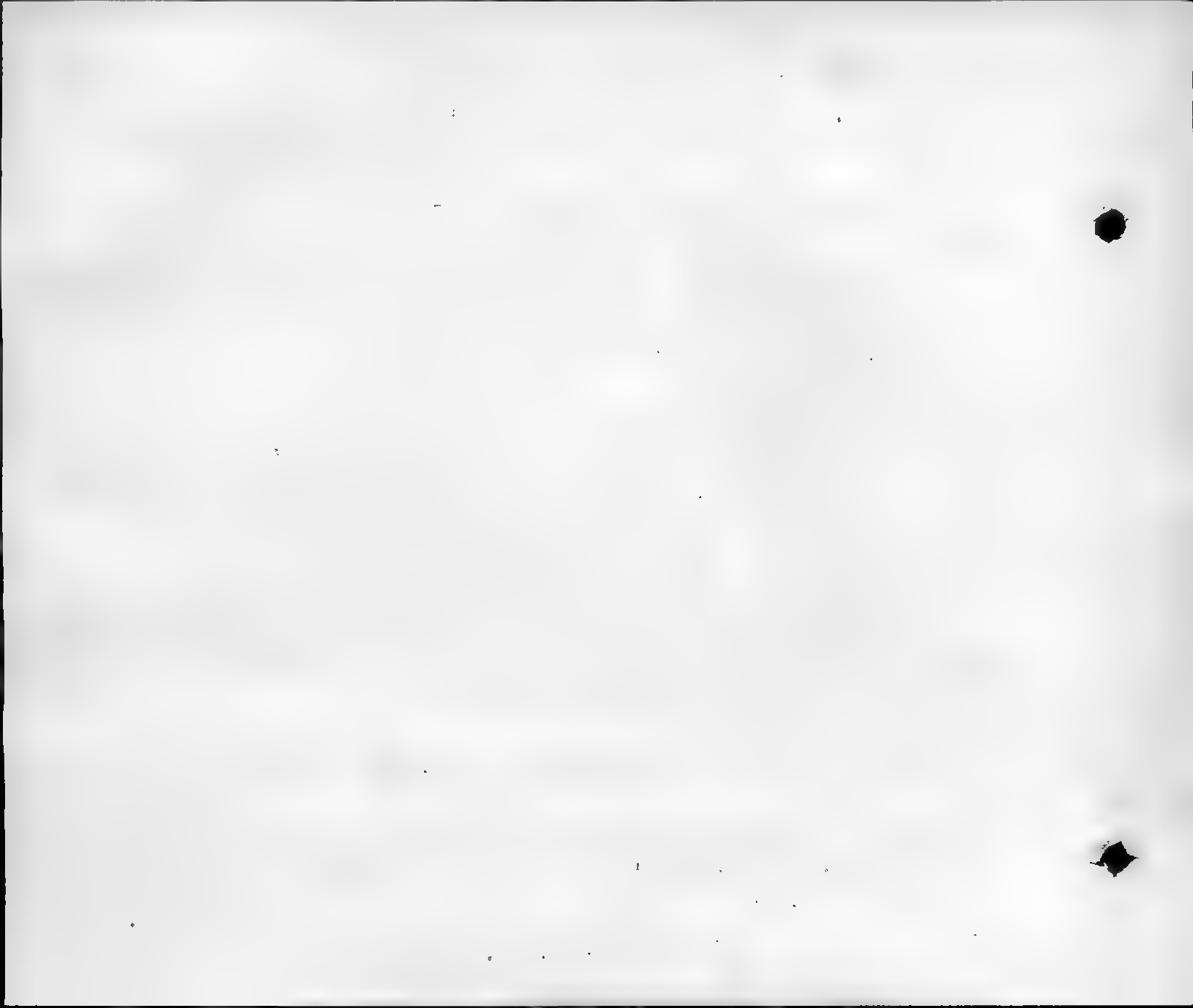
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3263

03251

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admittance) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>			
c. LENGTH OF STAY IN 1b <b>34 DAYS</b>				d. STREET ADDRESS <b>R-1, Box 206</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>FLYNN</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 27, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS FLYNN</b>				14. MOTHER'S MAIDEN NAME <b>EMMA CRAWFORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>4-5-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>10 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/10/1961</b> to <b>3/23/1961</b> , that (I) (we) last saw the deceased alive on <b>3/21/1961</b> , and that death occurred at <b>9:20p</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>James P. Kerr, M.D.</b>				22b. ADDRESS <b>DAMASCUS, MARYLAND</b>		22c. DATE SIGNED <b>3/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. P. KERR, M. D.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Howard Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Long Corner, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Moleaunth</b>				25a. REC'D BY REGISTRAR <b>Damascus, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinner</b>	

MEDICAL CERTIFICATION





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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this certificate, should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

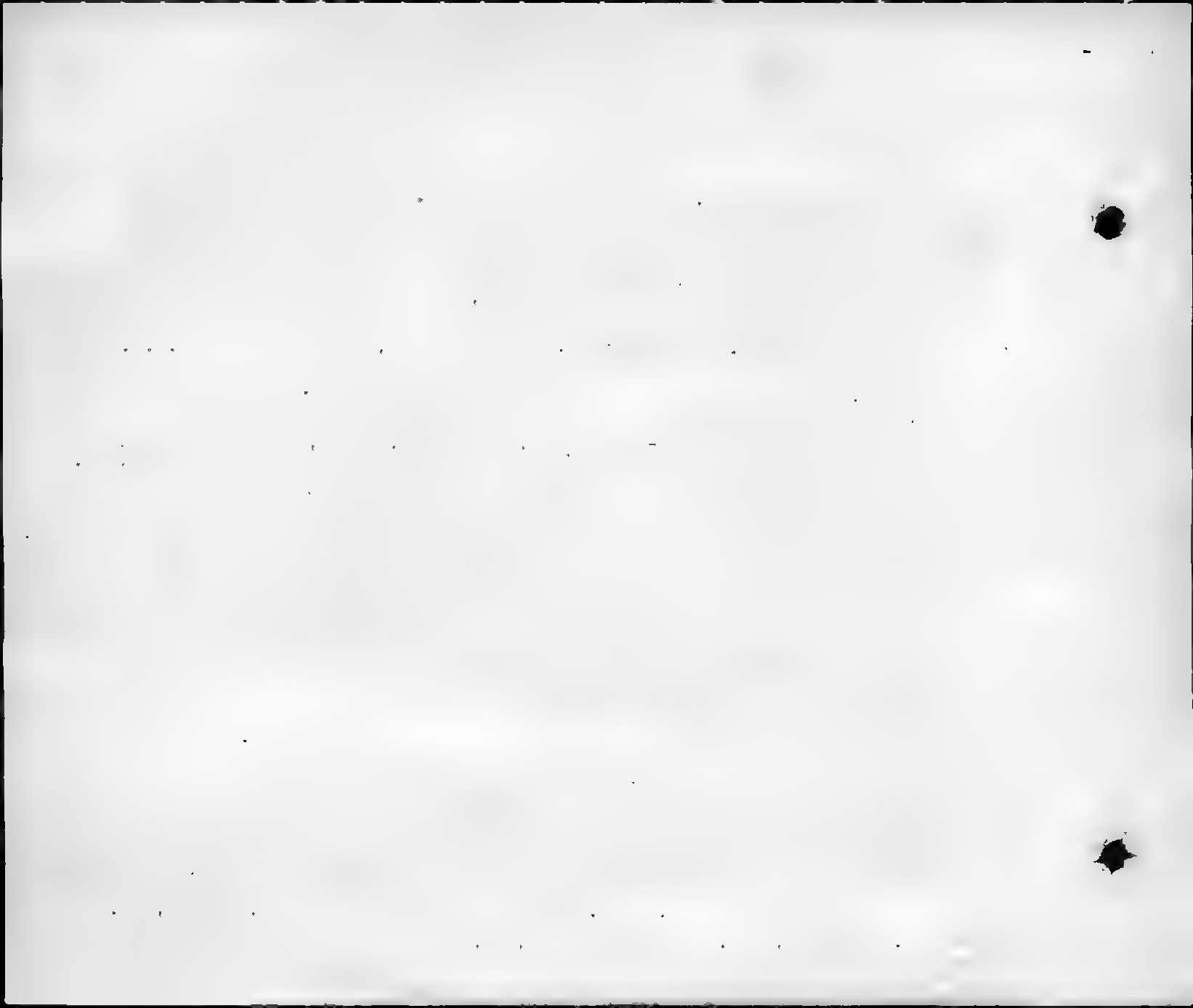
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3264

CERTIFICATE OF DEATH

03252

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. STREET ADDRESS 10 LAUER TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STANLEY BARBOUR FOLTZ		4. DATE OF DEATH Month Day Year MARCH 9 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1894
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (retired) Wash.		10b. KIND OF BUSINESS OR INDUSTRY Post Newspaper	
11. BIRTHPLACE (State or foreign country) ALEXANDRIA, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE J. FOLTZ		14. MOTHER'S MAIDEN NAME MARY N. BARBOUR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-03-2876	
17. INFORMANT Address MRS. FRANCES E. FOLTZ, 10 Lauer Terrace Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 Uremia (Acute Renal Failure) 1 week (b) Chronic Cirrhosis of Liver Undetermined (c) Diabetes Mellitus Undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jun 1, 1958 to Mar 9, 1961, that (I) (we) last saw the deceased alive on Mar 9, 1961 and that death occurred at PM from the causes and on the date stated above.			
22a. SIGNATURE George L. Ball M.D.		22b. DATE SIGNED Mar 9, 1961	
22c. PHYSICIAN'S NAME (Type) George L. Ball		22d. ADDRESS 10620 Georgia Ave Silver Spring, Md	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/11/61	
23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Pomeroy, Inc. Raymond L. Pomeroy		ADDRESS SILVER SPRING, MD.	
25a. REC'D BY REGISTRAR DATE MAR 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
3265			
03253			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, indicate type and date of admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) Months Days Hours M n.		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO		10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/17, 1961, to MAR 27, 1961, that (I) saw the deceased alive on 3/26, 1961, and that death occurred at 4:15 PM, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4  
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VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3266  
CERTIFICATE OF DEATH  
03254

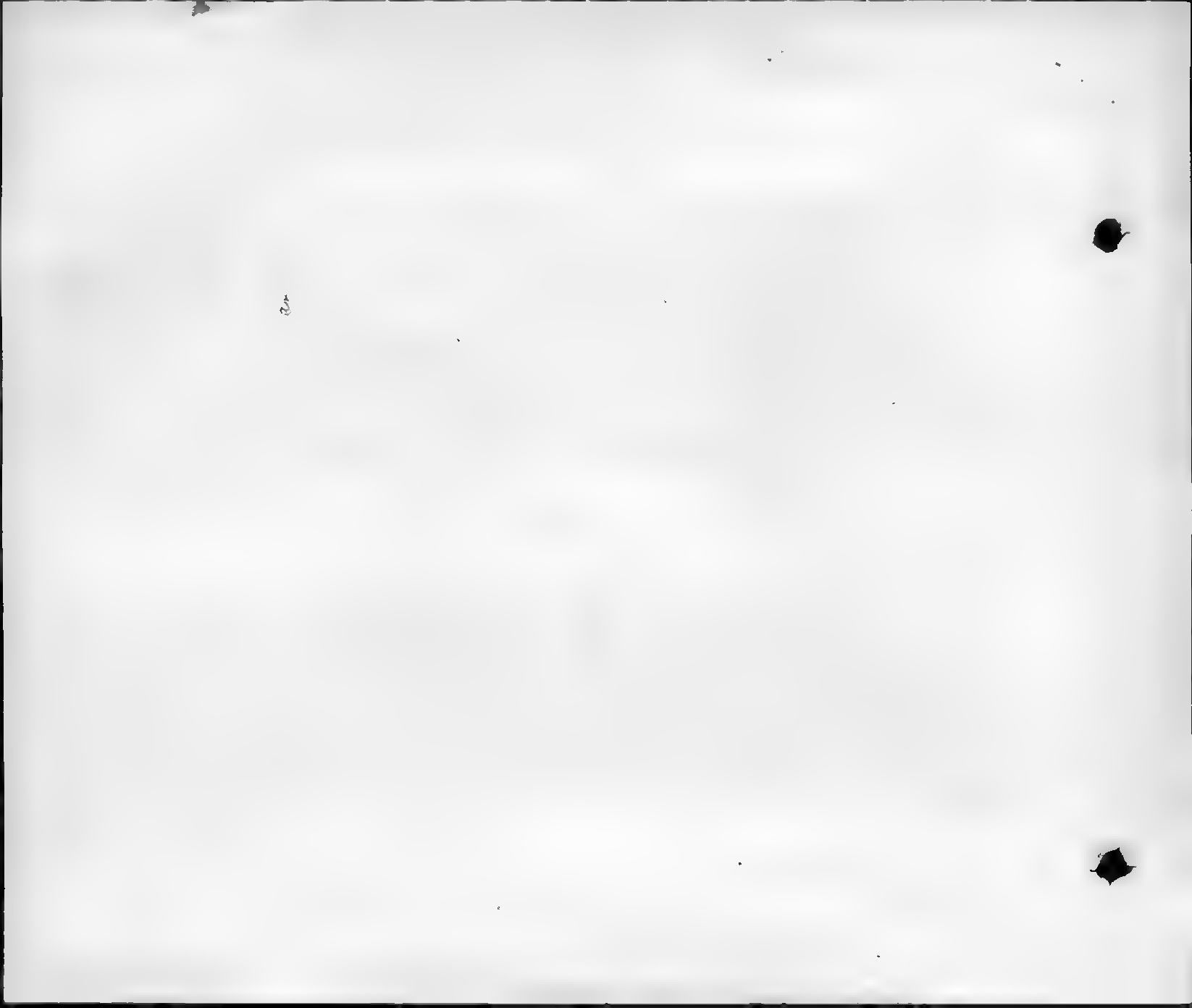
1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>13 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> d. STREET ADDRESS <b>14000 Layhill Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>Charles Lee Frazier</b>		4. DATE OF DEATH <b>March 5 1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1961</b>
9 AGE (n years last birthday) <b>12</b>		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b> <b>57</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Eddie Bain Frazier, Jr.</b>		14 MOTHER'S MAIDEN NAME <b>Shirley Ann Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. <b>161.5</b> IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>3/5 1961</b> Hour a. m. <b>8:15A</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>3/4 1961</b> to <b>3/5 1961</b> , that (I) (we) last saw the deceased alive on <b>3/5 1961</b> and that death occurred at <b>8:15A</b> M, from the causes and on the date stated above			
22a SIGNATURE <b>Richard A. Yates M.D.</b>		22b DATE SIGNED <b>3/5/61</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. Richard A. Yates, M.D.</b>		22d ADDRESS <b>Olney, Maryland</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>3/9/61</b>	
23c NAME OF CEMETERY OR CREMATORY <b>County Burial Ground</b>		23d LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b REGISTRAR'S SIGNATURE <b>William L. Evans</b>		DATE <b>MAR 10 '61</b>	

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1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 3267 CERTIFICATE OF DEATH 03255

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b <b>4 days.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RESNOR Hospital</b>				d. STREET ADDRESS <b>5416 BUCKING ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET (NMM) GALLAGHER</b>				4 DATE OF DEATH Month Day Year <b>MARCH 9 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 22, 1875</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <b>5 17</b>		11. IF UNDER 24 HRS. Hours Min <b>5 17</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Johnstown Penna.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>JOHN DINSMORE</b>				14. MOTHER'S MAIDEN NAME <b>WATT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. H.R. GALLAGHER</b> Address <b>5416 BUCKING RD. BETHESDA, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>generalized arteriosclerosis</b> DUE TO <b>generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <b>Sept. 1957</b> to <b>March 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 4, 1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas E. Curtin</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Curtin</b>				22d. ADDRESS <b>4600 Connecticut Ave. N.W. Wash DC</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3/9/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAR 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4, should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

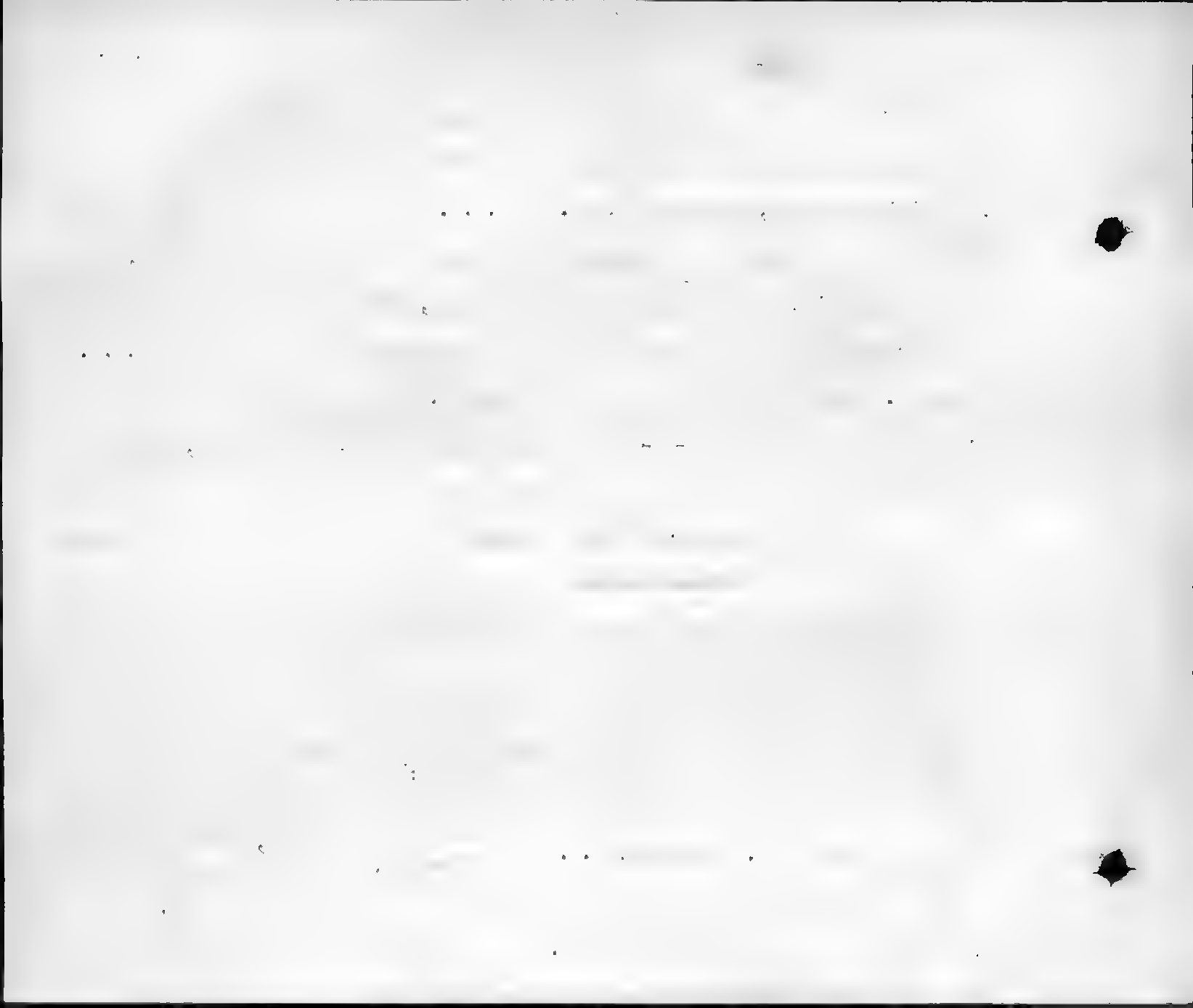
DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3268

CERTIFICATE OF DEATH

03256

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>82 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> d. STREET ADDRESS <b>R.F.D. # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Oswald Buchanan Garver</b>		4. DATE OF DEATH Month Day Year <b>March 7, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 2, 1911</b>
9. AGE (in years last birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Mechanic</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
13. FATHER'S NAME <b>George W. Garver</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-09-4327</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-abdominal Hemorrhage</b> DUE TO Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost (b) <b>Ruptured aortic aneurysm</b> DUE TO (c) <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Hours</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Histoplasmosis, disseminated</b>		19. WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 15, 1960</b> to <b>March 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>1:15 AM</b> from the causes and on the date stated above		22a. SIGNATURE <b>Robert R. Carpenter, M.D.</b> M.D. 22b. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert R. Carpenter, M.D.</b>		22d. DATE <b>3/7/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 10, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b> ADDRESS <b>Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 9 '61</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



3269

## CERTIFICATE OF DEATH

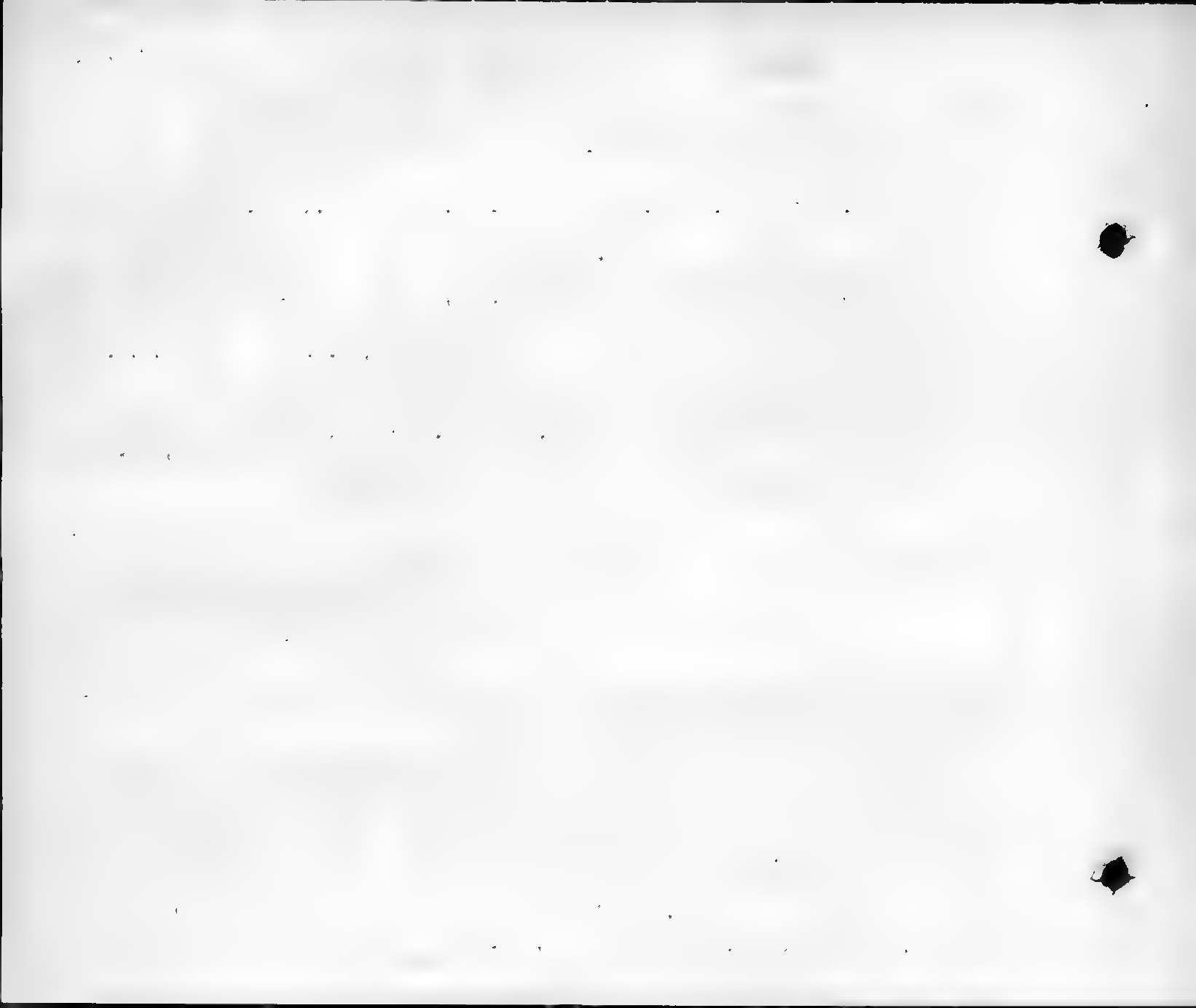
Reg. Dist. No.

03257

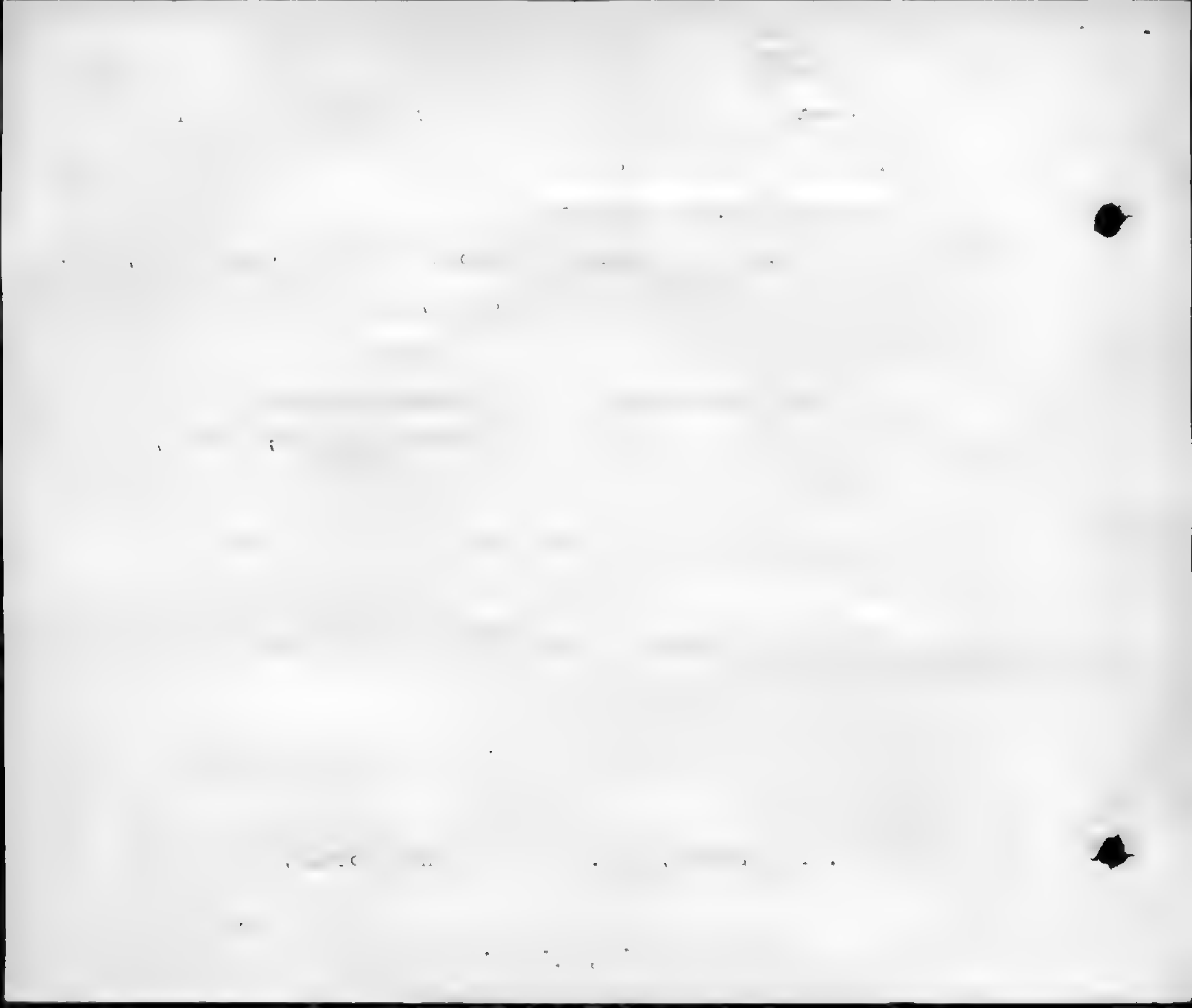
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 95 E. Wayne Ave., Apt. 412		d. STREET ADDRESS 95 E. Wayne Ave., Apt. 412	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROLYN L. GASKINS		4. DATE OF DEATH Month Day Year MARCH 23 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED DILOTT		14. MOTHER'S MAIDEN NAME MARIE LOUISE (UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. James R. Fryrear, 9702 Dilston Road Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHERS KNOWN CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Adenocarcinoma of lungs from breast 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1946 to 23 March, 1961, that I last saw the deceased alive on 23 March, 1961, and that death occurred at 10:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED WILLIAM D. AUD M.D. 9606 Calverville Rd, Silver Spring, Md. 3/23/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 3/27/61		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY	
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pompey, Inc. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 28 MAR 1961	
24b. REGISTRAR'S SIGNATURE Arthur L. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the medical examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 to the registrar, and Page 5 to the health officer. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
MONTGOMERY		Bethesda		12 hrs.		Maryland		Montgomery		Wheaton	
3. NAME OF DECEASED (Type or print)		Doris A. Glover		5. SEX		Female		6. COLOR OR RACE		White	
7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		March 31, 1926		9. AGE (in years, months, days, hours, minutes)		26 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Saleslady		Dry Goods Store		Virginia		U.S.A.		James E. Yates		Mary Ann Rebidas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		10112 Lewis Dr.		Stanley B Glover (Husband)		Damascus Md	
No		216-30-4937		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Peritonitis</i> <i>Perforation of Stomach</i> DUE TO (b) <i>14" 3</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)		24e. REC'D BY REGISTRAR	
Burial		3-24-61		Arlington Nat'l.		Arlington, Virginia		MAR 23 '61		DATE	
23. FUNERAL DIRECTOR		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE	
Francis H. Baker		Laytonsville, Md.		Arthur L. Hines		Arthur L. Hines		Arthur L. Hines		Arthur L. Hines	

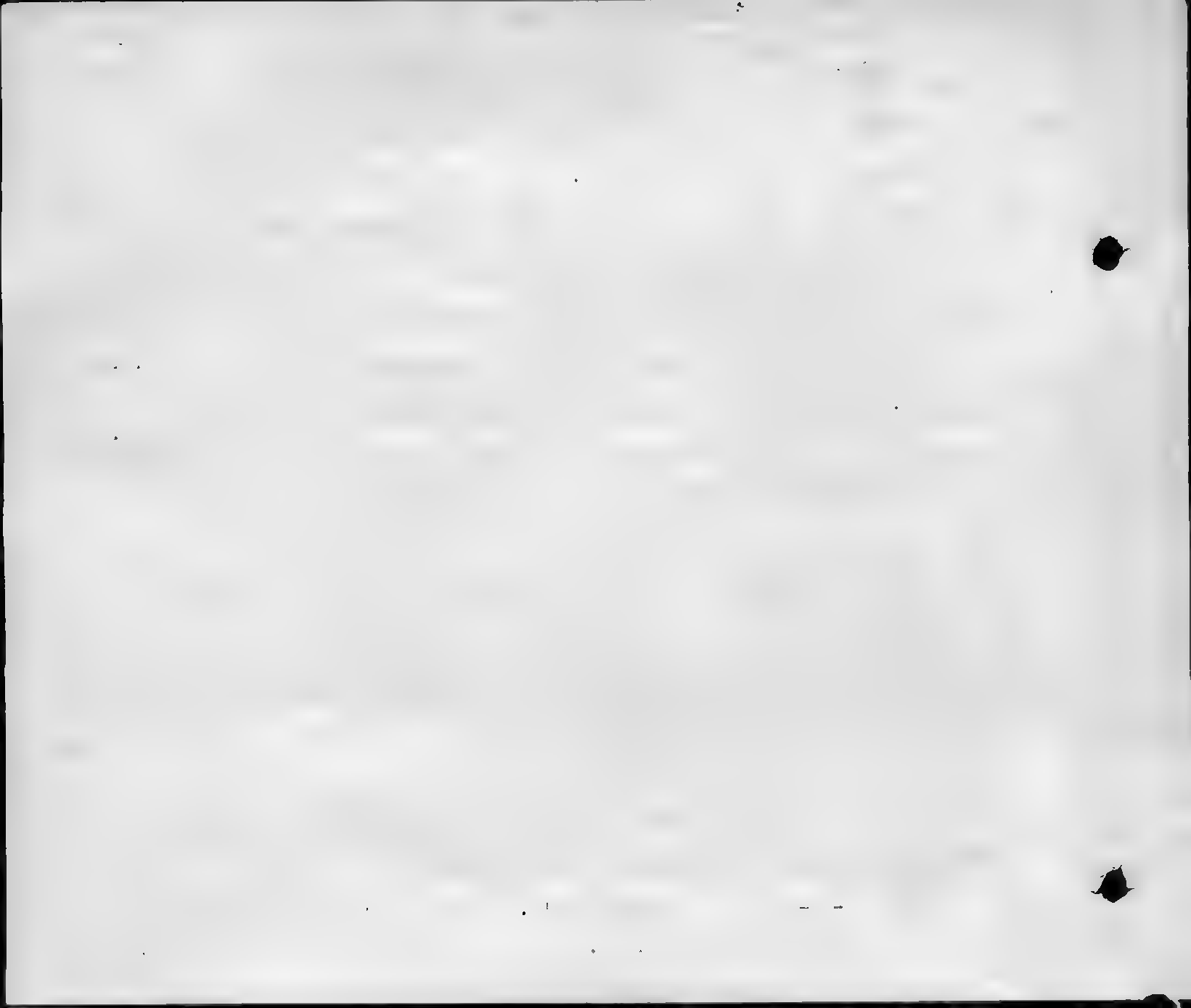
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3272

## CERTIFICATE OF DEATH

Reg. Dist. No.

03260

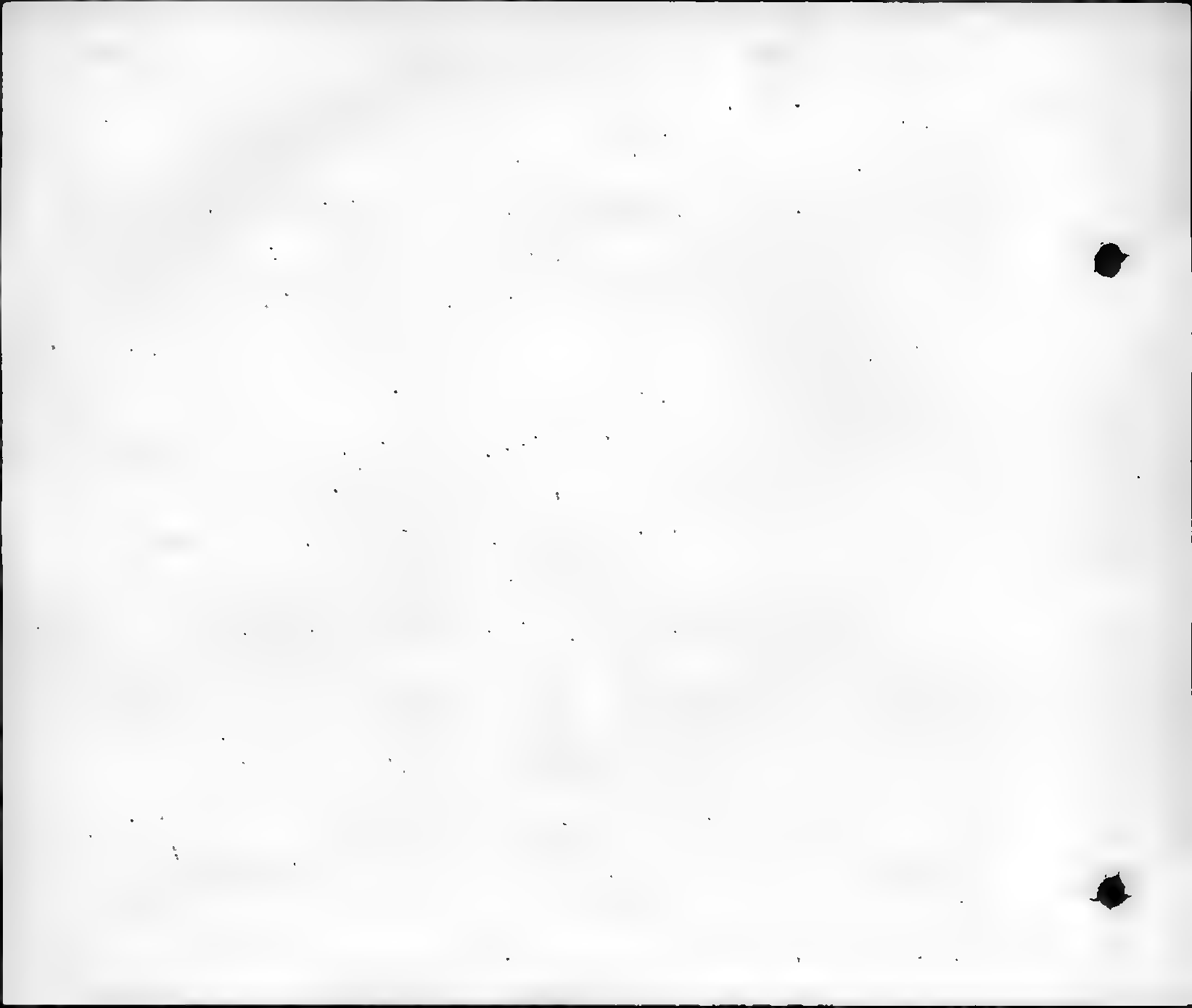
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>RURAL - ROCKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Rockville</u>			
c. LENGTH OF STAY IN 1b <u>6 Mo.</u>				d. STREET ADDRESS <u>4502 WOODLARK PLACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4502 WOODLARK PLACE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS - GOLDBERG</u>				4. DATE OF DEATH Month Day Year <u>MARCH 13 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1890</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>AARON GOLDBERG</u>				14. MOTHER'S MAIDEN NAME <u>DEBORAH TEPPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>077-28-4107 (Chm)</u>		INFORMANT Address <u>Goldberg 4502 Woodlark Place</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>5 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1958</u> to <u>March 13, 1961</u> that I last saw the deceased alive on <u>March 13, 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave 3/13/61</u>					
PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY, M.D.</u>		<u>Silver Spring Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ORADELL, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BERNARD DANZANSKY &amp; SONS - 3501-14th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

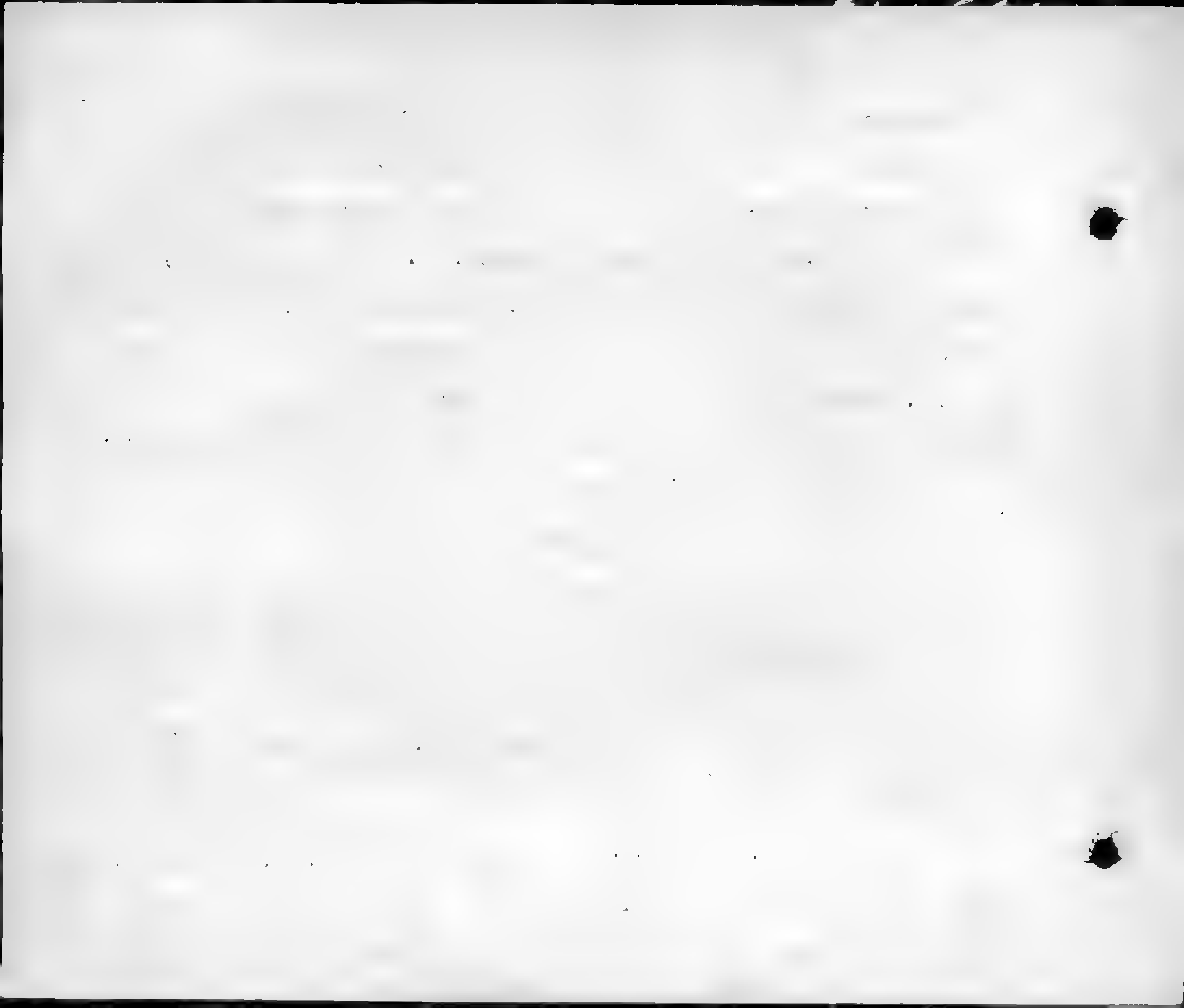


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 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595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3273 CERTIFICATE OF DEATH 03261

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>10 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Charleston</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charleston</b> d. STREET ADDRESS <b>2505 Cherokee Avenue</b> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Lynn Goshorn, Jr.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 61</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 10, 1915</b>
9. AGE (In years lost birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>	11 BIRTHPLACE (State or foreign country) <b>New Mexico</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John L. Goshorn</b>	
14. MOTHER'S MAIDEN NAME <b>Jennie Thomas</b>		15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>Not Available</b>		17 INFORMANT <b>The Medical Record,</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> <b>165.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Metastatic Bronchogenic Carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 Minutes</b> <b>6 Months</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 20, 19 61</b> to <b>March 2, 19 61</b> , that (I) (we) last saw the deceased alive on <b>March 2, 19 61</b> and that death occurred at <b>8:40 AM</b> from the causes and on the date stated above.			
22a SIGNATURE <b>Vincent H. Bono Jr.</b> M.D.		22b DATE SIGNED <b>3/2/61</b>	
22c PHYSICIAN'S NAME (Type) <b>Vincent H. Bono M.D.</b>		22d ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>3-6-61</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Springhill</b>		23d LOCATION (City, town, or county) (State) <b>Charleston W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul General Home</b>		25a REC'D BY REGISTRAR <b>MAR 6 '61</b>	
ADDRESS <b>4812 H Avenue NW Wash. DC.</b>		25b REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

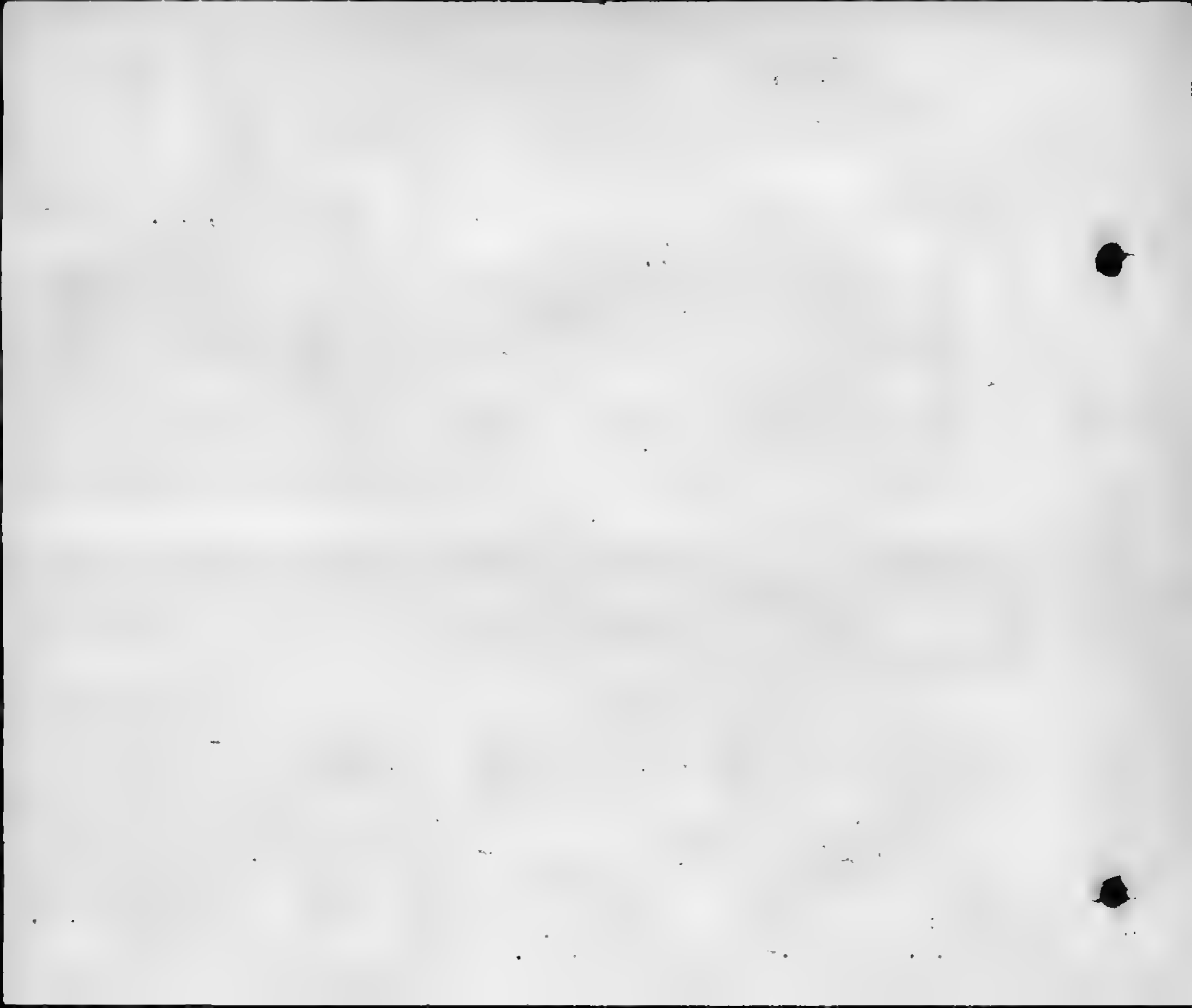
## CERTIFICATE OF DEATH

3274

13263

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution - Residence before admission) a. STATE <b>DC</b> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kenilworth</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CARROLL HALL 10231 Carroll Place</b>				d. STREET ADDRESS <b>417 Van Buren Street, N.W.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>OLIVE Y. GRAHAM</b>		<b>4. DATE OF DEATH</b> <b>MARCH 15 1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>OCT. 15 - 1875</b>	<b>9. AGE</b> (In years last birthday) <b>85</b> yrs	<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	<b>11. IF UNDER 24 HRS</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>John EDMONDSON</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>NANCY RICKMAN</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO</b> <b>yes ?</b>			
<b>17. INFORMANT</b> <b>Records at Carroll Hall Sanitarium</b>				<b>18. CAUSE OF DEATH</b> (Enter on only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <b>Carcinoma, generalized, primary site undetermined.</b> DUE TO (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c): <b>Generalized arteriosclerosis</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>March 9 1961</b> <b>to</b> <b>March 15 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>March 9 1961</b> , <b>and that death occurred at</b> <b>11:00 A.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Blaine H. Eig</b>				<b>22b. DATE SIGNED</b> <b>March 15 1961</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>BLAINE H. EIG</b>				<b>22d. ADDRESS</b> <b>444 Cleveland Blvd., N.W.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/18/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Prince Georges County, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>MAR 16 '61</b> <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
3275 03263									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			c. LENGTH OF STAY IN b. <b>21 yrs.</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6822 Delaware Street</b>						d. STREET ADDRESS <b>6822 Delaware Street</b>			
3. NAME OF DECEASED (Type or print) <b>WARREN WHYTE GRIMES</b>			4. DATE OF DEATH <b>March 5 1961</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>male</b>			6. COLOR OR RACE <b>white</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>			10b. KIND OF BUSINESS OR INDUSTRY			9. AGE (in years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR: Months <b>5</b> Days <b>5</b> IF UNDER 24 HRS.: Hours <b>5</b> Min.			
11. BIRTHPLACE (County & State or foreign country) <b>Alexandria, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Franklin Pierce Grimes</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hunter</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>?</b>			17. INFORMANT <b>Helen Grimes--Chevy Chase, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary arteriosclerosis</b> DUE TO <b>Interval between ONSET AND DEATH 3 hours</b>									
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3/5/58</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3/5/58, 19, to 3/5, 1961, that (I) (we) last saw the deceased alive on 3/3, 1961, and that death occurred at 11:45 AM, from the causes and on the date stated above</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3/5/58</b> , 19, to <b>3/5</b> , 1961, that (I) (we) last saw the deceased alive on <b>3/3</b> , 1961, and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above			22a. SIGNATURE <b>John A. Reisinger</b>			22b. DATE SIGNED <b>3/5/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>John A. REISINGER</b>			22d. ADDRESS <b>901-20th N.W. WASH. D.C.</b>						
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Cremation 3/8/61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory Prince Georges County, Md.</b>			23d. LOCATION (City, town or county) (State) <b>Washington 9, D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.</b>			25a. REC'D BY REGISTRAR <b>MAR 7 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knapp</b>			

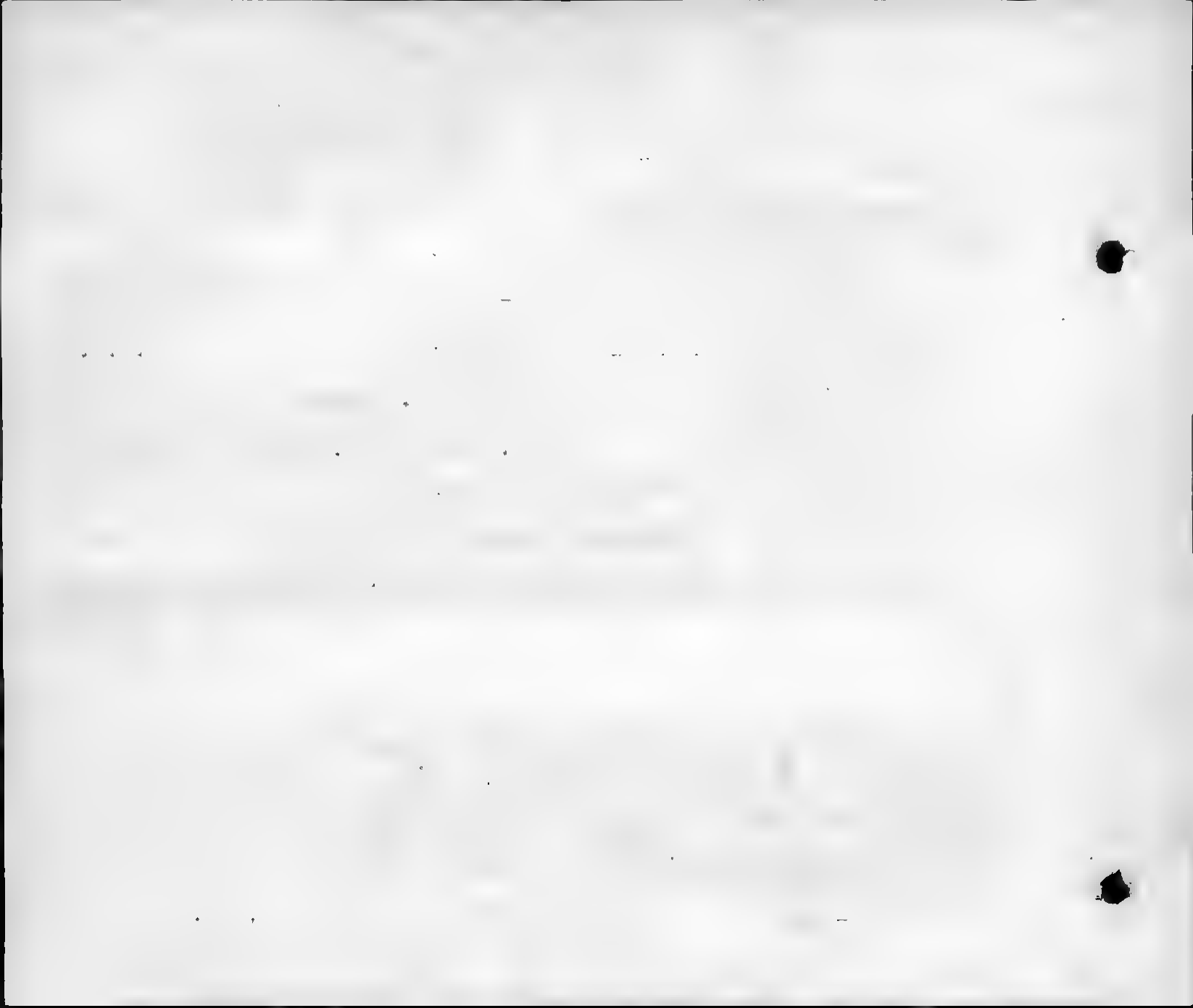
1919



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**3276** **CERTIFICATE OF DEATH** **03264**

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b - - -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Sanitarium</b>				e. STREET ADDRESS <b>1622 Fitzgerald Lane</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <b>Lucy</b> First Middle Last <b>Guttridge</b>				4 DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-1878</b>	9. AGE (In years last birthday) <b>82</b> yrs.	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carter Williams</b>				14. MOTHER'S MAIDEN NAME <b>Emily F. Leavitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT <b>Mrs. Virginia G. Mayers (Daughter)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
331X DUE TO				(b) <b>Cerebral vascular accident</b>			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.				DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <input type="checkbox"/> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1960</b> to <b>March 23, 1961</b> that (I) (we) last saw the deceased alive on <b>March 23, 1961</b> , and that death occurred on <b>March 23, 1961</b> at <b>9:30 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.				22b. DATE SIGNED <b>March 23, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr., M.D.</b>	
22d. ADDRESS <b>801 Veins Mill Road Rockville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>3-27-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudin &amp; Sons, Inc. 1756 Pa. Ave. N.W.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2. In by the funeral director, and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3277

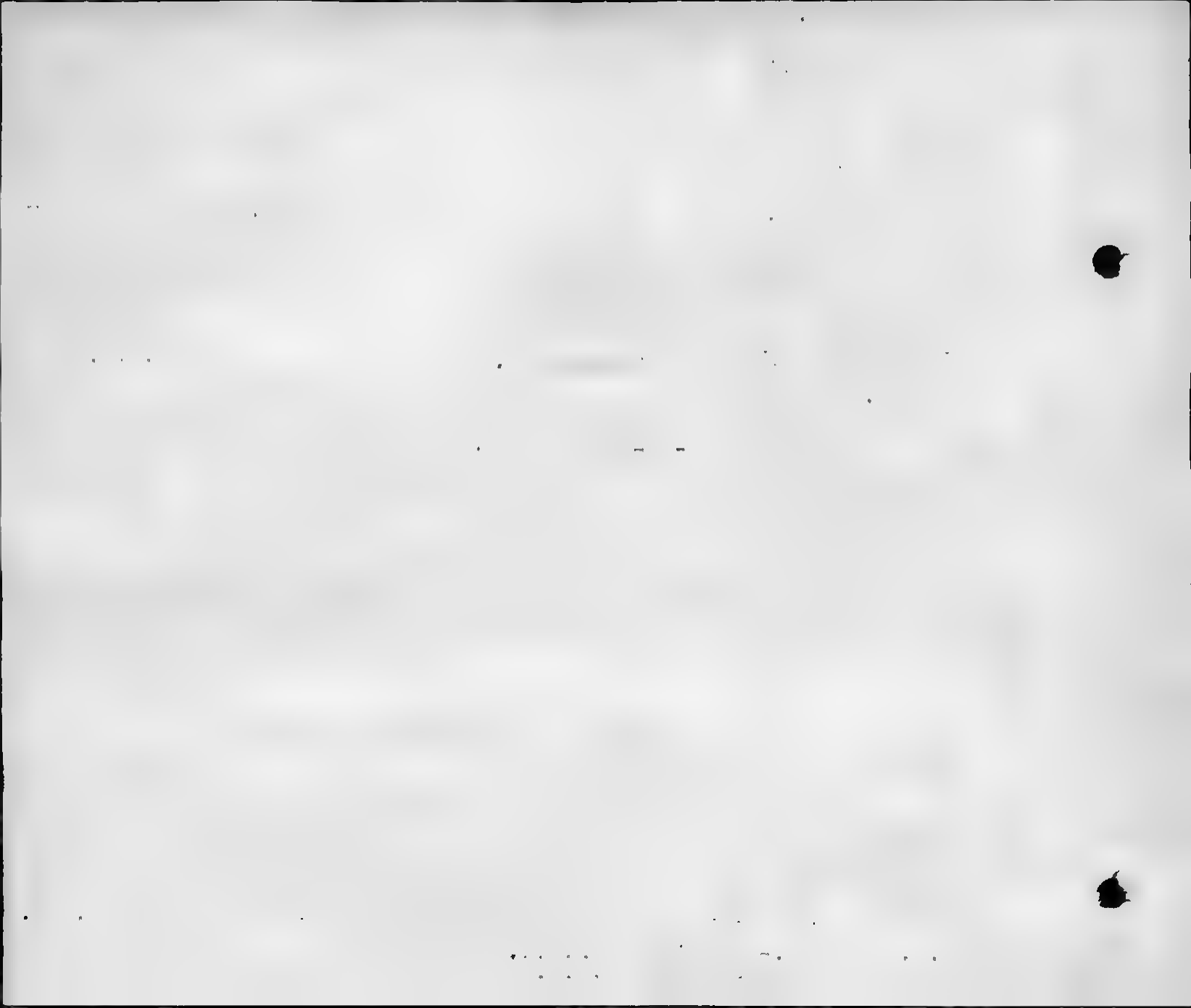
## CERTIFICATE OF DEATH

03265

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> c. LENGTH OF STAY IN 1b <u>7900 Glendale Rd.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>7900 Glendale R.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Edward Halley</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>17</u> Year <u>1961</u>		
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/27/78</u>	
<b>9. AGE</b> (In years last birthday) <u>82</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>12a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>President of Washington Planograph Co.</u>		<b>12b. KIND OF BUSINESS OR INDUSTRY</b> <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>Edward S. Halley</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Blair</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>578-07-7678</u>		<b>17. INFORMANT</b> <u>Paul F. Loehler same as #2</u>
<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO (b) <u>hypertensive heart disease</u> (a), stating the underlying cause last. (c) <u>  </u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>heart</u>				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> When? <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)				
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>2/1</u> 19 <u>56</u> to <u>3/17</u> 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/17</u> 19 <u>61</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above				
<b>22a. SIGNATURE</b> <u>John E. Everett</u>		<b>22b. DATE SIGNED</b> <u>3/17/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN E. EVERETT</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/20/1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co.</u>		<b>24b. ADDRESS</b> <u>-2901 14th St., N.W.</u>		<b>24c. CITY</b> <u>Washington 9, D.C.</u>
<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 20 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Cirincus S. Prange</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. The certificate should be forwarded to the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03266											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN life <u>life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>218 N. Washington St.</u>				d. STREET ADDRESS <u>218 N. Washington St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Elias Hammond</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>18,</u> Year <u>1961</u>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/1901</u> 94		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>				11. BIRTHPLACE (State or foreign country) <u>Ma.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Laggie Giddings</u>				Address <u>Rockville, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>				17. INFORMANT <u>Geo. W. Johnson 222 N. Washington St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>											
DUE TO (b) <u>  </u>											
DUE TO (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>				20h. (State) <u>  </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Mar. 20, 1961</u>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>  </u>				22b. DATE THEREOF <u>3/27/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u>			
22d. LOCATION (City, town, or county) <u>Rockville, Md.</u>				22e. (State) <u>  </u>				22f. (Country) <u>  </u>			
23. FUNERAL DIRECTOR <u>Robert L. Suroden</u>				ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				24c. (City, town, or county) <u>  </u>				24d. (State) <u>  </u>			



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

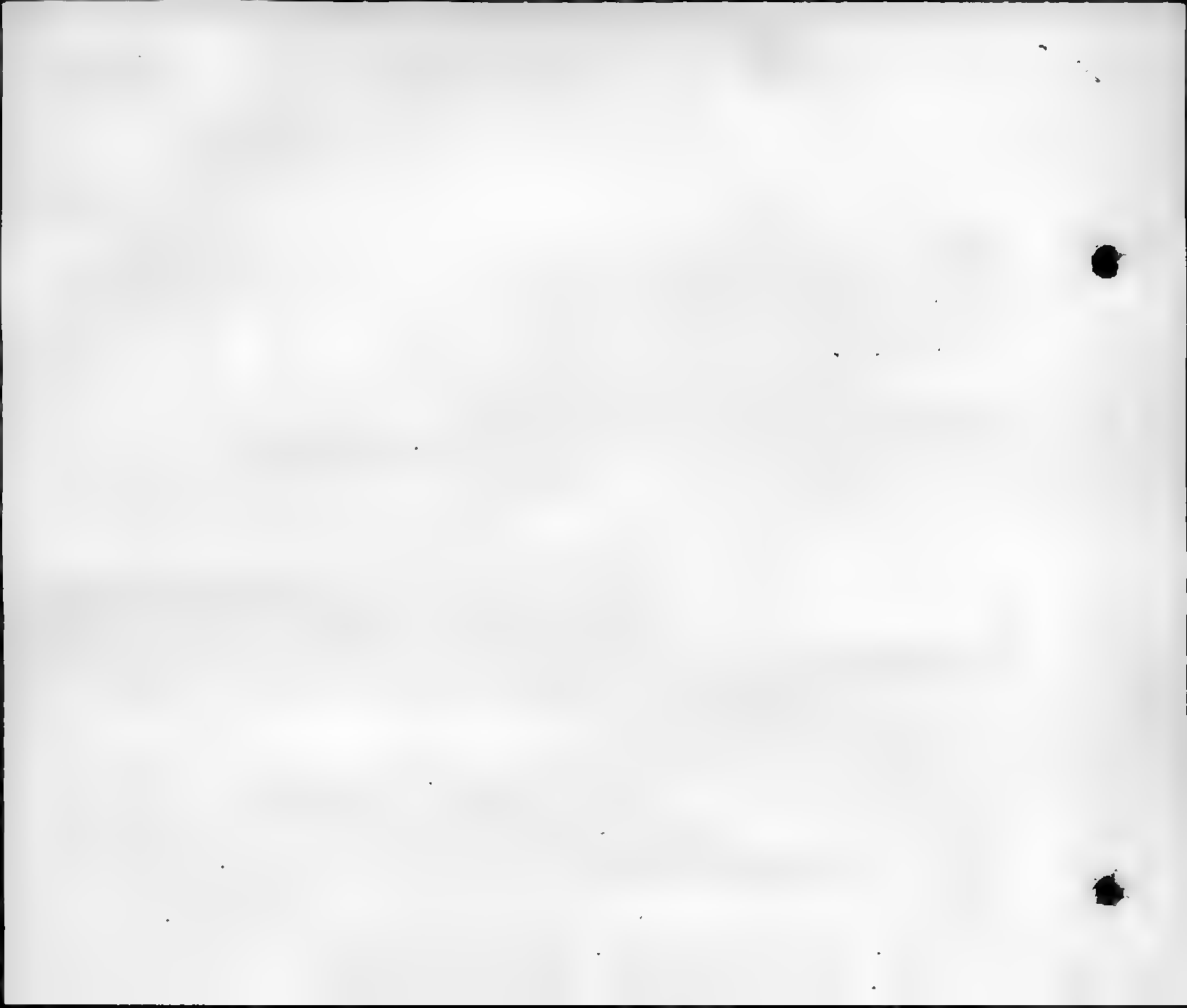
3279

CERTIFICATE OF DEATH

Item 23b, 231-0284 4/8/61 iwc

03267

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4740 Bradley, Boulevard</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BETHNOR Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Washington</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5 - 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>24</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Harris</u>		14. MOTHER'S MAIDEN NAME <u>Maria Fish</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>George J. Harris-son-</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCD</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 mos</u> <u>25 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>3 June 1960</u> to <u>29 March 1961</u> , that (1) (we) last saw the deceased alive on <u>29 March 1961</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Robert Young</u>		22b. DATE SIGNED <u>3/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Young</u>		22d. ADDRESS <u>2500 Calvert St., N.W. Washington, D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REG-STRAR <u>3/29/61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krame</u>	





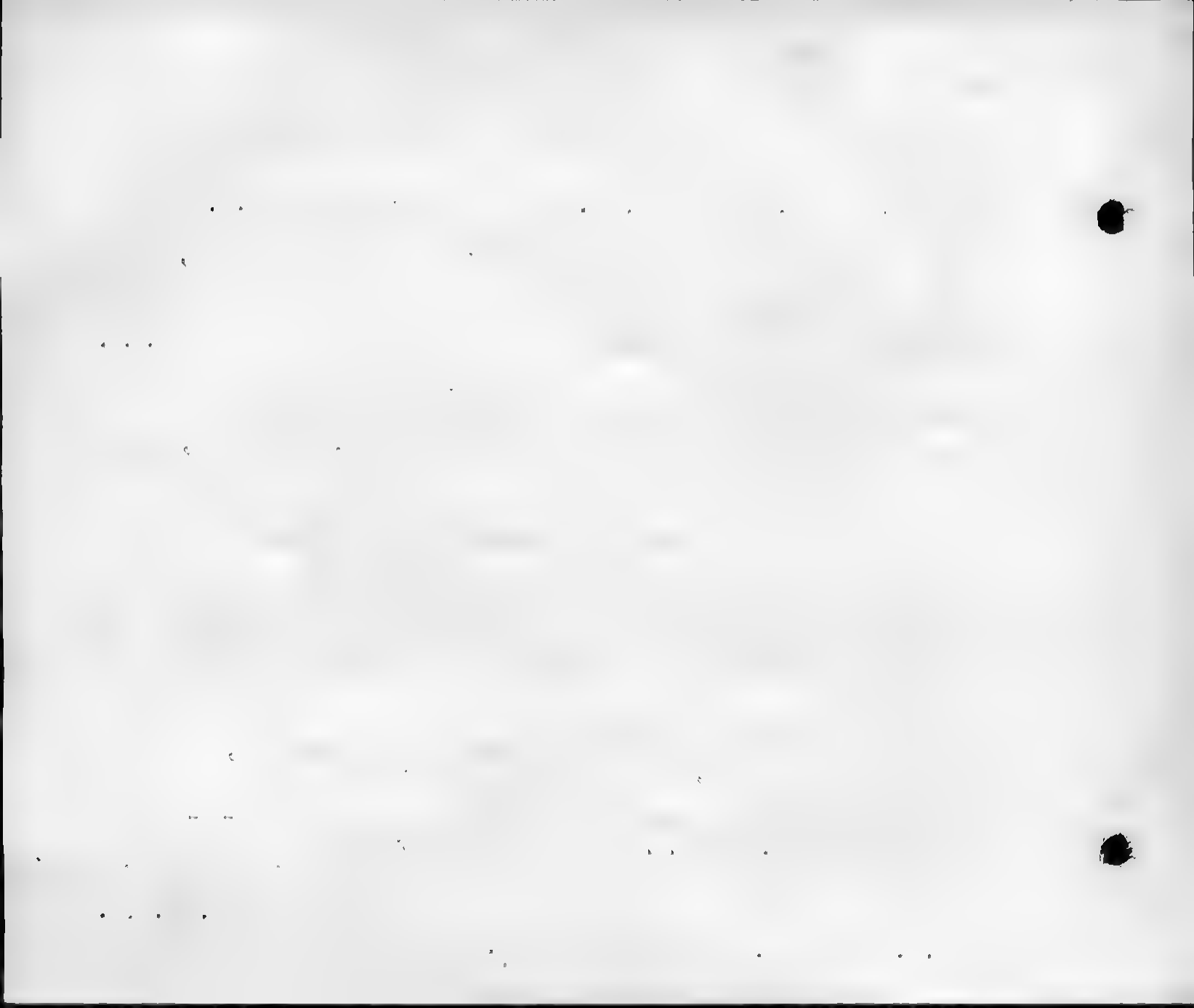
3280

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03268

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>63 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>916 Cottage Street, S.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Ora</b> Middle <b>Vance</b> Last <b>Hartbarger</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 61</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1923</b>
9 AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Harry Hartbarger</b>		14. MOTHER'S MAIDEN NAME <b>Cleopatria Hughes</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW II Unascertainable</b>	
17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>uremia</b> DUE TO (b) <b>chronic hereditary nephritis</b> DUE TO (c) <b>chronic hereditary nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>17 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>January 26, 19 61</b> to <b>March 30, 19 61</b> that (I) (we) last saw the deceased alive on <b>March 30, 19 61</b> , and that death occurred at <b>4:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Norman H. Bell</b>		22b. DATE SIGNED <b>3-30-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Norman H. Bell M.D.</b>		22d. ADDRESS <b>National Institutes of Health The Clinical Center, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>4/1/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hartbarger Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lexington, Va. (R.F.D.#1)</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>APR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>O. Hines &amp; Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 and be enclosed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

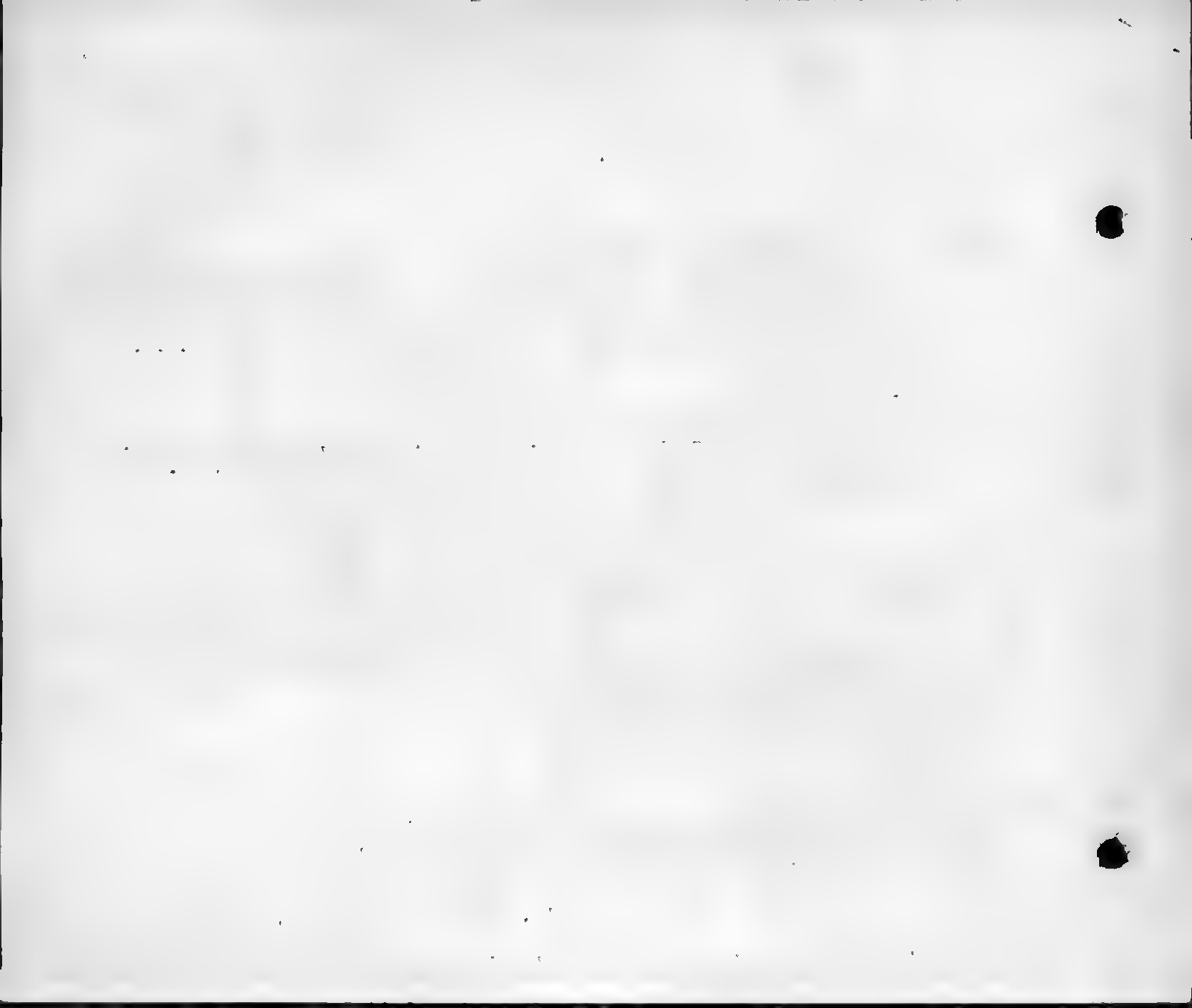
3281

## CERTIFICATE OF DEATH

Reg. Dist. No. **03269**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span>		<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>12 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>215 HILLMOOR DRIVE</b>		e. STREET ADDRESS <b>215 HILLMOOR DRIVE</b>	
<b>3 NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First <b>HARRIE</b></span> <span>Middle <b>GAY</b></span> <span>Last <b>HASKIN</b></span> </div>		<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month <b>MARCH</b></span> <span>Day <b>9</b></span> <span>Year <b>19 61</b></span> </div>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/10/88</b>
<b>9 AGE</b> (In years last birthday) <b>73 yrs</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Auto Salesman (retired)</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Emerson &amp; Orme Buick</b>
<b>11. BIRTHPLACE</b> (State or foreign country) <b>WISCONSIN</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JAMES W. HASKIN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MARIA EMPEY</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> <b>WW# 1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>577-18-7609</b>	
<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mrs. Nellie R. Haskin, 215 Hillmoor Dr.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b>  <b>4201</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="flex: 2;"> <b>Silver Spring, Md.</b>  <b>Coronary artery thrombosis &amp; myocardial infarction &amp; resultant congestive failure</b>  <b>12 hrs.</b> </div> </div>			
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>1948</b> , 19____, to <b>9 March, 1961</b> , that I last saw the deceased alive on <b>9 March, 1961</b> , and that death occurred at <b>6: A.M.</b> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>Ernest E. Harmon</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>9301 Colesville Road</b> <b>Silver Spring, Maryland</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>ERNEST E. HARMON</b>		<b>DATE SIGNED</b> <b>3/9/61</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>3/13/61</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NAT'L. CEMETERY</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>WALTER E. PUMPHREY, INC.</b> <b>Raymond A. Jick</b>		<b>ADDRESS</b> <b>SILVER SPRING, MD.</b>	
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 15 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3282

## CERTIFICATE OF DEATH

Reg. Dist. No. 03270

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11703 JUDSON ROAD</b>				d. STREET ADDRESS <b>11703 JUDSON ROAD</b>			
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>HAUG</b> Last <b>HAUG</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 6, 1909</b>		9. AGE (In years last birthday) <b>EX 51 yrs.</b>	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. GOVERNMENT EMPLOYEE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>FREDERICK DAVID HAUG</b>				14. MOTHER'S MAIDEN NAME <b>FREDA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO <b>RONALD RICH 816 UNIVERSITY BLVD., E. S.S., MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary oc Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>Coronary atherosclerosis</b> DUE TO (c) <b>atherosclerosis, coronary</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/15/61</b> to <b>3/27/61</b> , that I last saw the deceased alive on <b>3/26/61</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave., S.S., Ind.</b> DATE SIGNED <b>3/27/61</b> ACTUAL SIGNATURE <b>Donald Nelson</b> PHYSICIAN'S NAME (Type) <b>DR. DONALD NELSON</b> <b>10620 GEORGIA AVE., S.S., MD.</b>							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-29-61</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>KING DAVID MEMORIAL GARDEN</b>		22d. LOCATION (City, town or county) (State) <b>FALLS CHURCH, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS-3501 14th Street, NW</b>				24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3283

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11327

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>PARKERSBURG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN MD.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKERSBURG</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARLANDER REST HOME</u>				d. STREET ADDRESS <u>PARKERSBURG</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA DUDLEY HEATON</u>				4. DATE OF DEATH Month Day Year <u>MARCH 3 1961</u>			
SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 24 1887</u>	
9. AGE (In years and birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hwr</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PARKERSBURG W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN W. DUDLEY</u>				14. MOTHER'S MAIDEN NAME <u>EMMA G. LEONARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GENERAL LEONARD J. HEATON</u> Address <u>WRAMC AC.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15 1961</u> to <u>3/3 1961</u> , that (I) (we) last saw the deceased alive on <u>3/3 1961</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>James P. Kerr</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		22d. ADDRESS <u>Lamascus, Md.</u>		22b. DATE SIGNED <u>3/3/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 6, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET</u>		23d. LOCATION (City, town, or county) (State) <u>PARKERSBURG W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u> ADDRESS <u>816 N. N.E. AC2</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

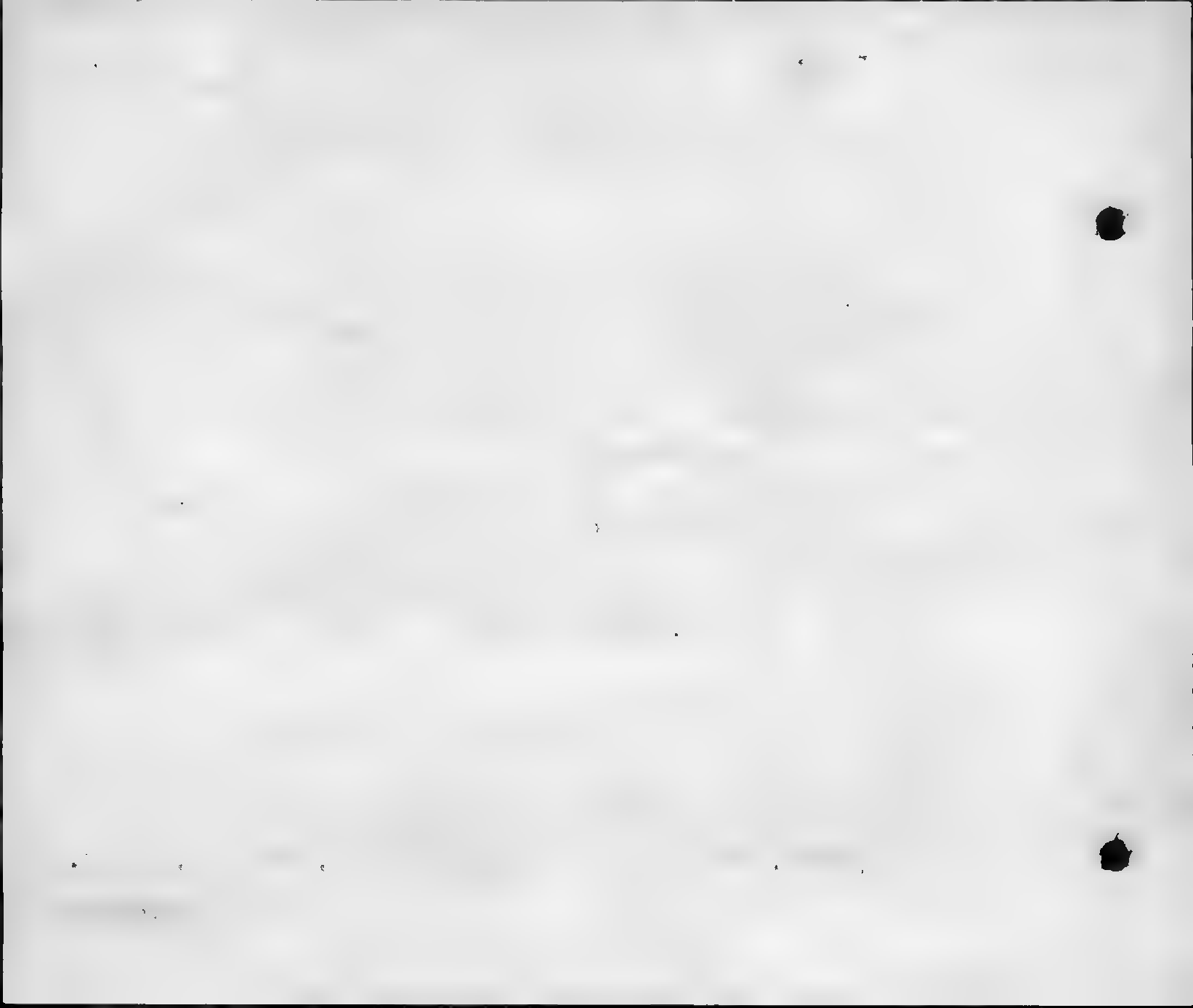
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3284

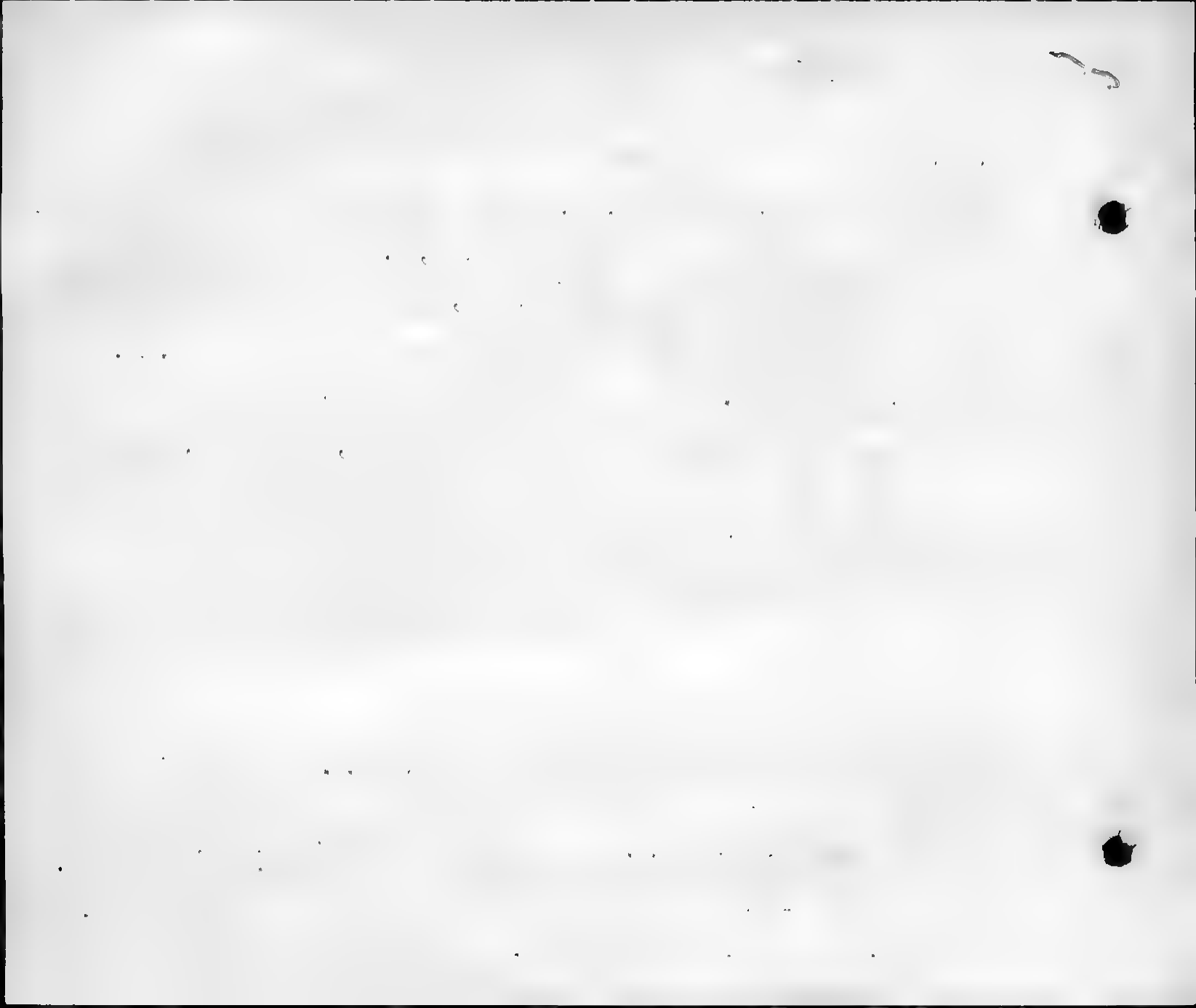
03272

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>426 Pershing Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nannie Fowler</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HLU</u>		9. AGE (In years, last birthday) <u>75</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Birkhead</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fowler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hosp Records</u>	
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) <u>Adenocarcinoma of Lung</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Cerebral Vascular Accident</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>road</u>	
20f. (City or town) <u>Frederick</u>		20g. (County) <u>Frederick</u>		20h. (State) <u>Md</u>	
21. I, certify that (I) (this hospital) attended the deceased from <u>Feb 15, 1961</u> to <u>Mar 9, 1961</u> ; that (I) (we) last saw the deceased alive on <u>3/4</u> 19 <u>61</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED <u>Mar 14 '61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>		22d. ADDRESS <u>7600 Carrol Ave, Takoma Park, Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3.13.61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT WINSTON CEM.</u>	
23d. LOCATION (City, town or State) <u>WASH D.C.</u>		23e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birkhead</u>		24a. ADDRESS <u>3034 West Hill</u>		DATE <u>MAR 14 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>70 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Erie</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75X -</b> d. STREET ADDRESS <b>926 West 16th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard John Hellman, Jr.</b>				4. DATE OF DEATH Month Day Year <b>March 20 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1958</b>	
9. AGE (In years last birthday) <b>2</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Richard John Hellman, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Patricia Shearer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b> 199X DUE TO (b) <b>Metastatic Ca, Embroanal Cell</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 9 1961</b> to <b>March 20 1961</b> , that (I) (we) last saw the deceased alive on <b>March 20 19 61</b> and that death occurred at <b>3:45 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Michael Z. Lazor</b>				22b. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22c. DATE <b>3/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MICHAEL Z. LAZOR, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22e. DATE <b>3/20/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 3-21-61</b>		23b. DATE THEREOF <b>3-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Erie, County, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 23 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hauer</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3286

CERTIFICATE OF DEATH

03276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 15 <u>1 mo 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1508 - 18th St. S.E.</u>		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert John Hook</u>		4. DATE OF DEATH <u>Mar. 28 1961</u>		9. AGE (In years last birthday) <u>78</u> yrs			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH-PLACE (County & State, or foreign country) <u>Penn.</u>			
13. FATHER'S NAME <u>Abraham L. Hook</u>		14. MOTHER'S MAIDEN NAME <u>Annie Fritz</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>153</u> DUE TO (b) <u>Post operative inactivity</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) <u>Surgery for Ca. Recto sigmoid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 27, 1961</u> to <u>March 28, 1961</u> , that (1) <u>no</u> last saw the deceased alive on <u>March 28 1961</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <u>Welfred W. Eastman</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>		23d. LOCATION (City, town or county) (State) <u>BROADENSBURG MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold L. Hunter</u>		24b. ADDRESS <u>3831 So. G St. N.W.</u>		25a. REC'D BY REGISTRAR <u>APR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunter</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

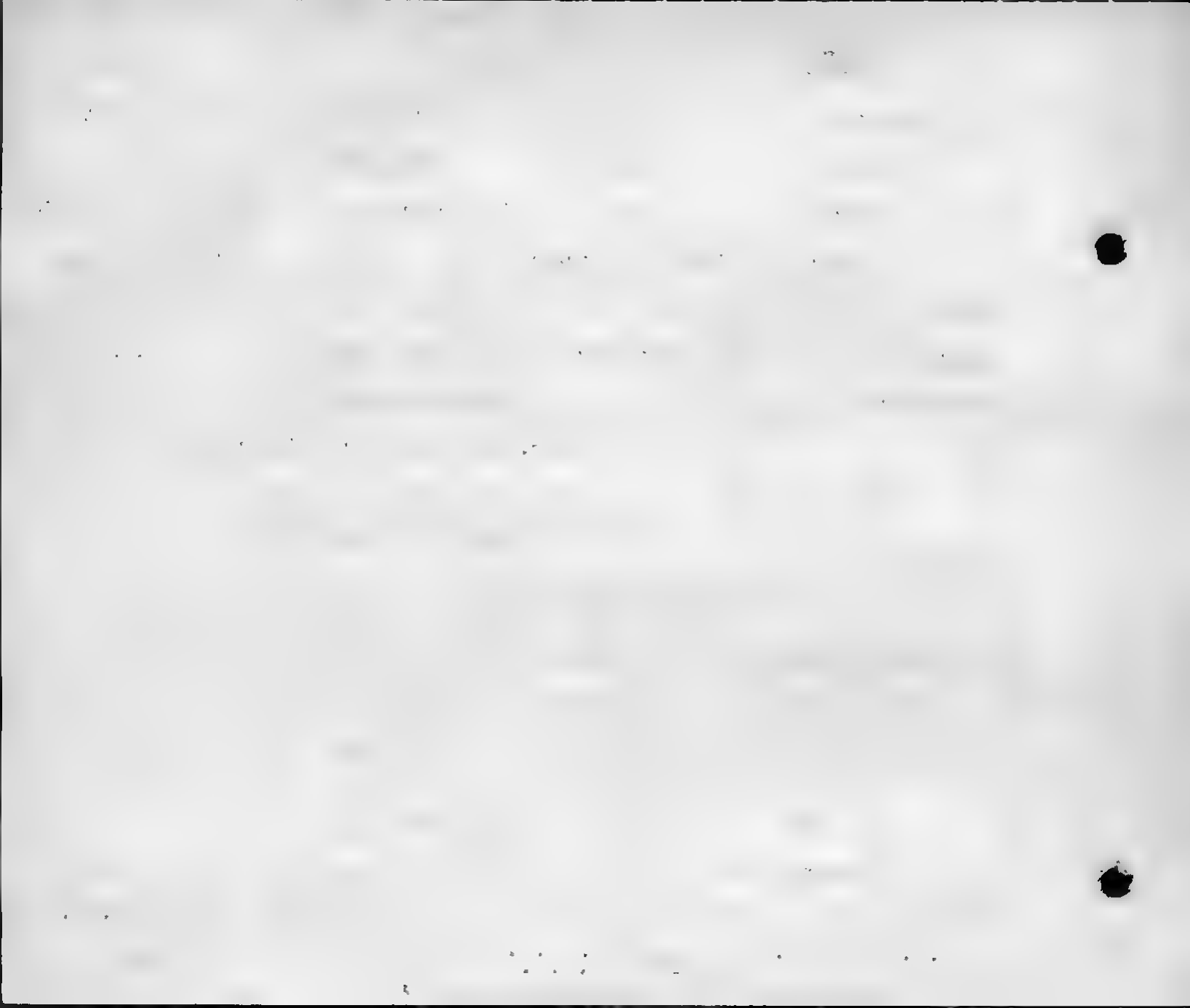
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3287

## CERTIFICATE OF DEATH

03275

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>108 Primrose Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary Snow Horton</b> 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>3/30/75</b> 9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New Jersey</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>George Horton</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown (If yes give year or dates of service)) <b>No</b> <b>16. SOCIAL SECURITY NO</b> <b>no</b> <b>17. INFORMANT</b> <b>Mrs. Florence Seward (Sister)</b> Address <b>Same as above</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Rich</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) <b>Septicemia, acute, severe</b> (b) <b>Hemolytic Staphylococcus</b> (c) <b>Source undetermined.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <b>Arteriosclerosis, generalised.</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1950</b> to <b>3/10/1961</b> , that (I) <del>(two)</del> last saw the deceased alive on <b>3/9/1961</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <i>Stewart Clapp</i> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Stewart Clapp</b>		<b>22b. DATE SIGNED</b> <b>3-10-61</b> <b>22d. ADDRESS</b> <b>4740 Chevy Chase Dr. Chevy Chase Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b> <b>3/11/1961</b>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln Crematory</b>		<b>23d. LOCATION (City, town or county)</b> <b>Prince Georges Co. Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co.</b> <b>2901 14th St. N.W.</b> <b>Washington 9, D.C.</b>		<b>25a. REC'D. BY REGISTRAR</b> <b>MAR 13 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove number 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

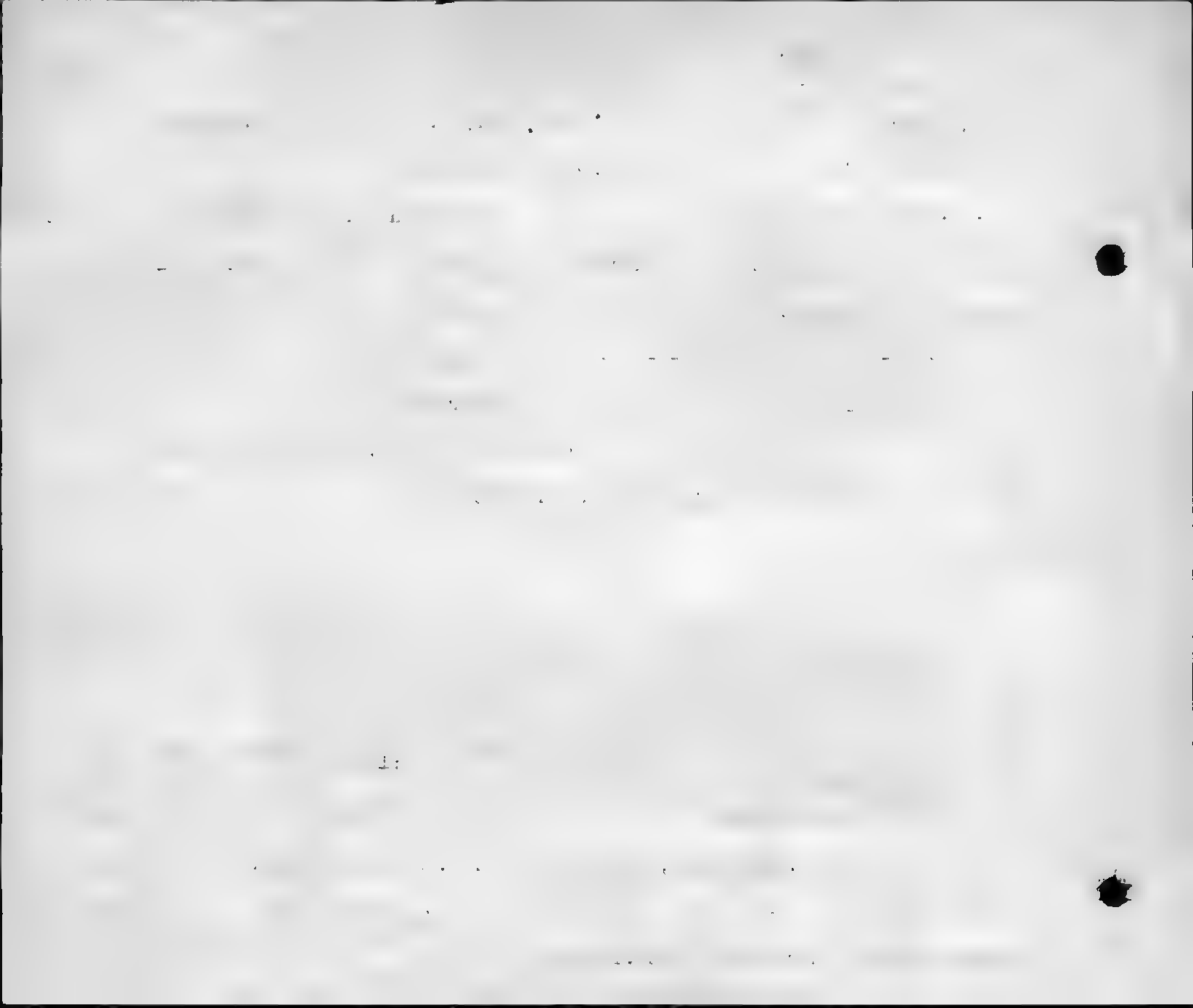
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3288

## CERTIFICATE OF DEATH

03276

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN b. <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1703 Tweed St., c/o Craig</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Coralee Theresa HULSEY</u>		<b>4. DATE OF DEATH</b> Year <u>1961</u> Month <u>March</u> Day <u>1</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-31-61</u> <b>9. AGE</b> (In years last birthday) <u>29</u> yrs. IF UNDER 1 YEAR: Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min. IF UNDER 24 HRS.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____ <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Germany</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Virgil HULSEY</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>(F) Virgil Hulsey, same as #2 above</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara WALL</u> <b>Address</b> _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus, congenital</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>29 days</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that</b> (if this hospital) attended the deceased from <u>Feb. 19 1961</u> to <u>March 1 1961</u> , that (a) (we) last saw the deceased alive on <u>March 1 1961</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Gail A. Magid</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Gail A. MAGID, LT, MC, USN</u>		<b>22b. DATE SIGNED</b> <u>3-1-61</u> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-Shipment</u> <b>23b. DATE THEREOF</b> <u>3-2-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mountain View Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Tacoma Washington</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler</u> <b>ADDRESS</b> <u>Tyson Wheeler Funeral Home, Rockville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 3 '61</u> <b>DATE</b> _____	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

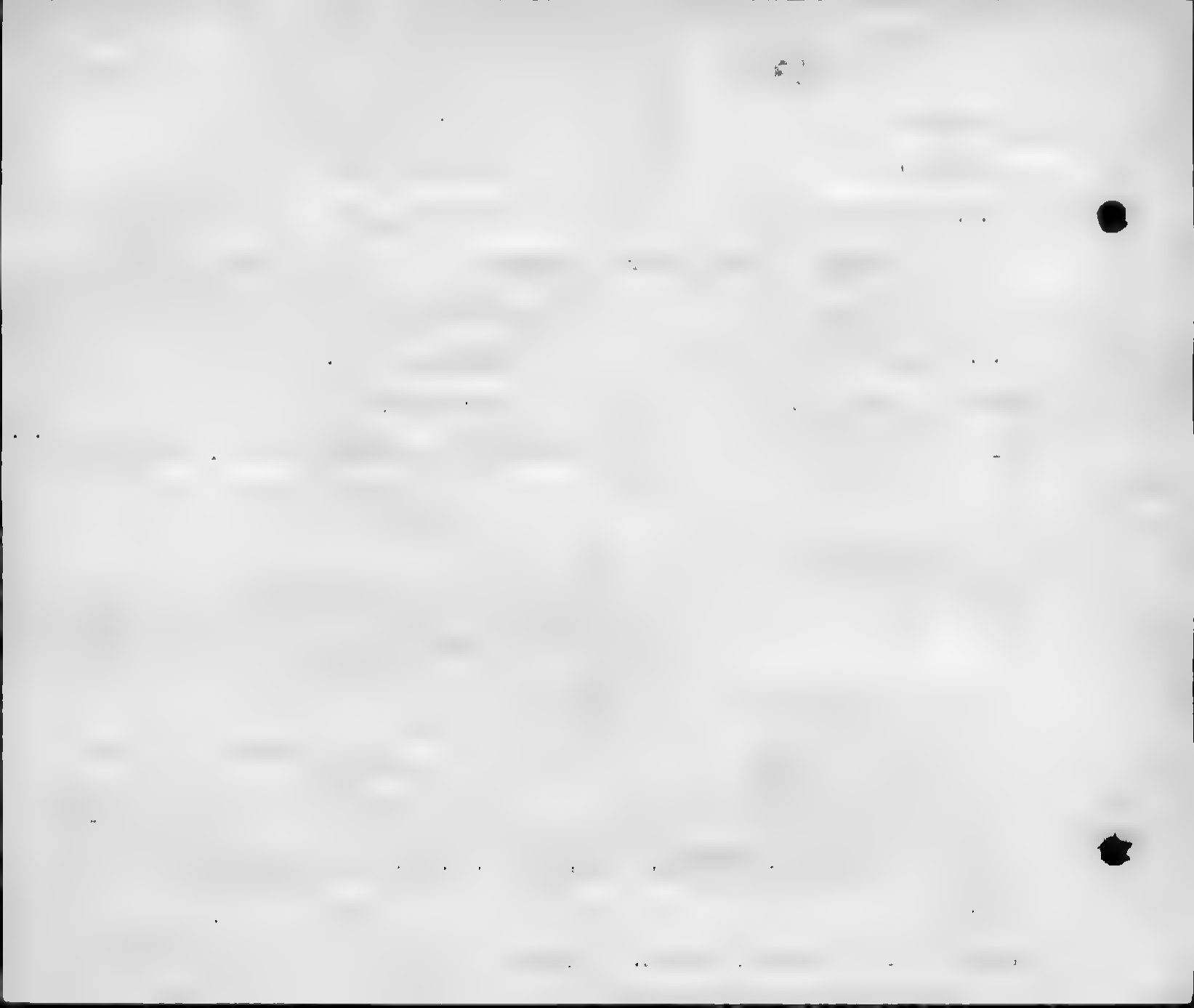
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3289

03277

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2501 Q St. NW</b>	
3. NAME OF DECEASED (Type or print) <b>Edward Shillingford HUTCHINSON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Male</b>		6. CO. OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 February 1904</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Philadelphia, Pa.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Hutchinson Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Clara Shillingford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>		16. SOCIAL SECURITY NO <b>Catherine Hutchinson 2501 Q St NW Washington D.C.</b>	
17. INFORMANT <b>Interval between onset and death minutes to hours</b>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>1. 120.0 Acute Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple old areas of myocardial infarction</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>10:20AM</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		20i. (City or town)	
20j. (County)		20k. (State)	
21. I certify that (this hospital) attended the deceased from <b>March 6, 1961</b> to <b>March 12, 1961</b> , that (we) last saw the deceased alive on <b>March 12, 19 61</b> , and that death occurred at <b>10:20AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Kenneth V. Harshman M.D.</b>		22b. DATE SIGNED <b>3-13-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kenneth V. HARSHMAN, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-15-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) <b>Arlington, Va.</b>	
24. GENERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's &amp; Sons 1756 Penn. St. NW WDC</b>		25. REC'D BY REGISTRAR <b>MAR 15 '61</b>	
25a. REGISTRAR'S SIGNATURE <b>Carlton S. Kram</b>		25b. REGISTRAR'S SIGNATURE	



1  
FOR STATE  
HEALTH DEPT.

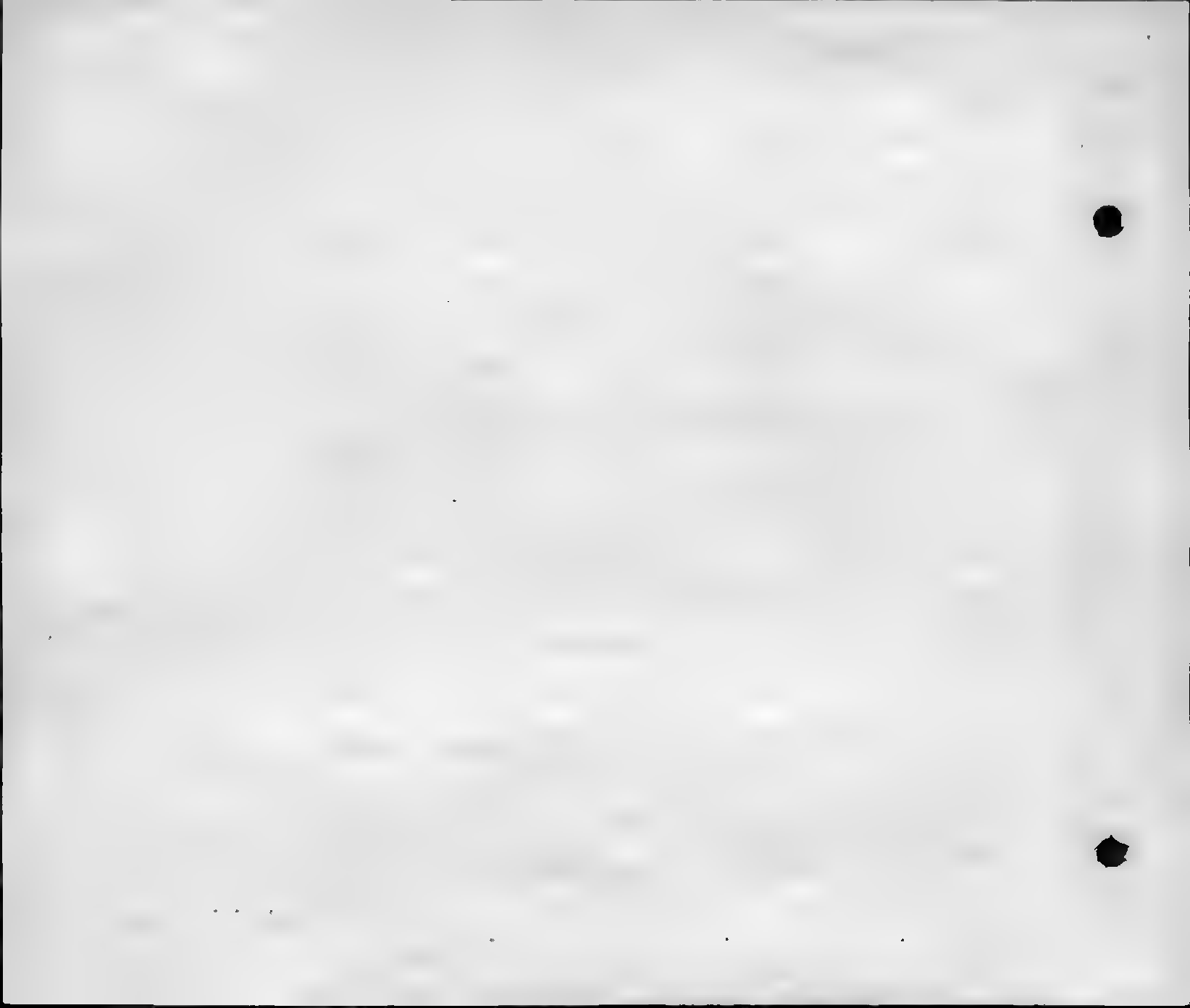
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. Give pages 1, 2, and 3 to the Medical Director. Pages 4 show the certificate forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

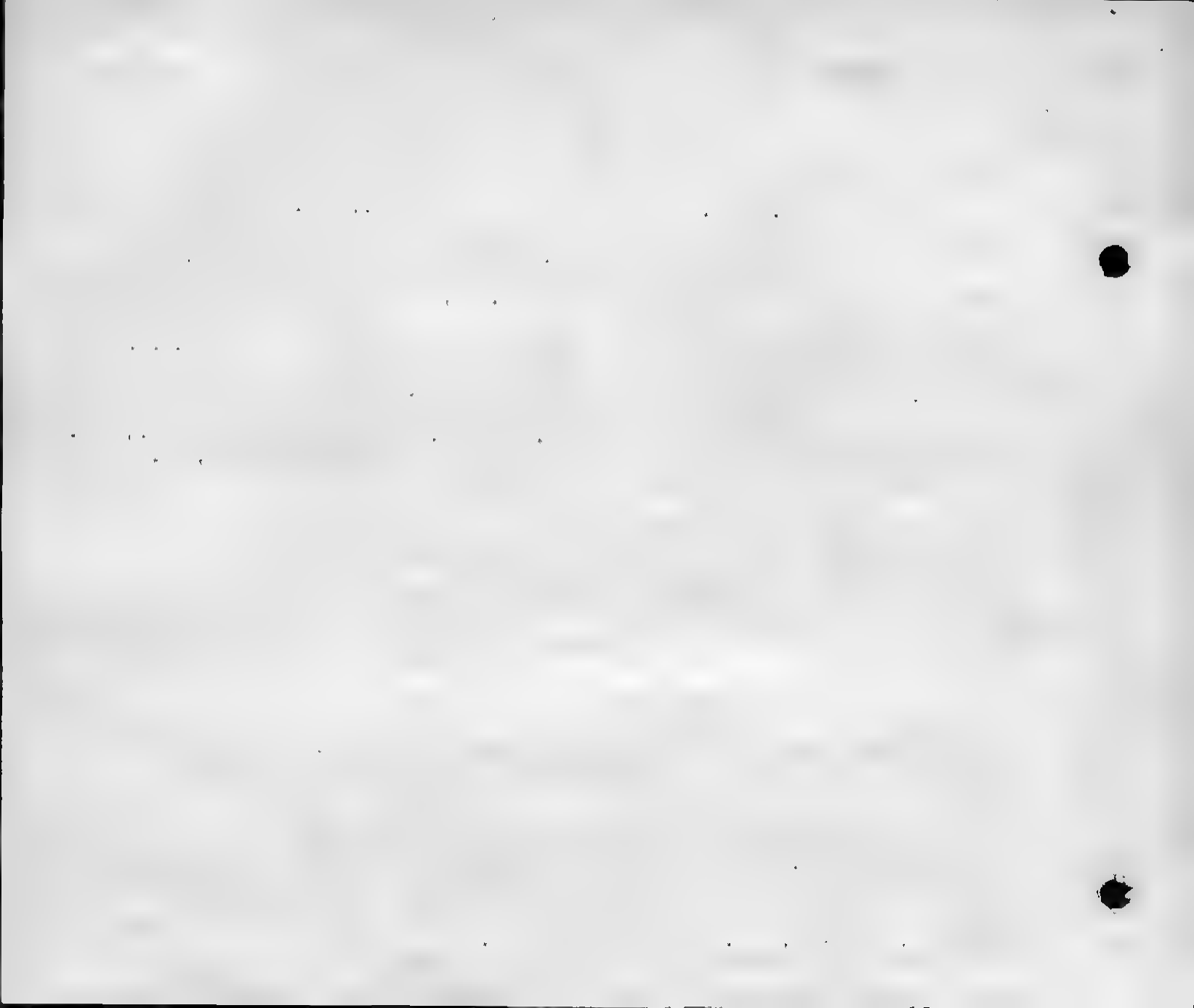
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03278

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
c. LENGTH OF STAY IN it <u>30 yrs</u>		d. STREET ADDRESS <u>Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Lee Jenkins</u>		4. DATE OF DEATH <u>Mar 15 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist - Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>M.S.C.</u>	
13. FATHER'S NAME <u>Don H. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Addie unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Melvin Lee Jenkins - R-2 Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, b.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural forces <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Zioka</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>MAR 20 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Adeline S. Knaus</u>		DATE <u>3-15-61</u>	

MEDICAL CERTIFICATION





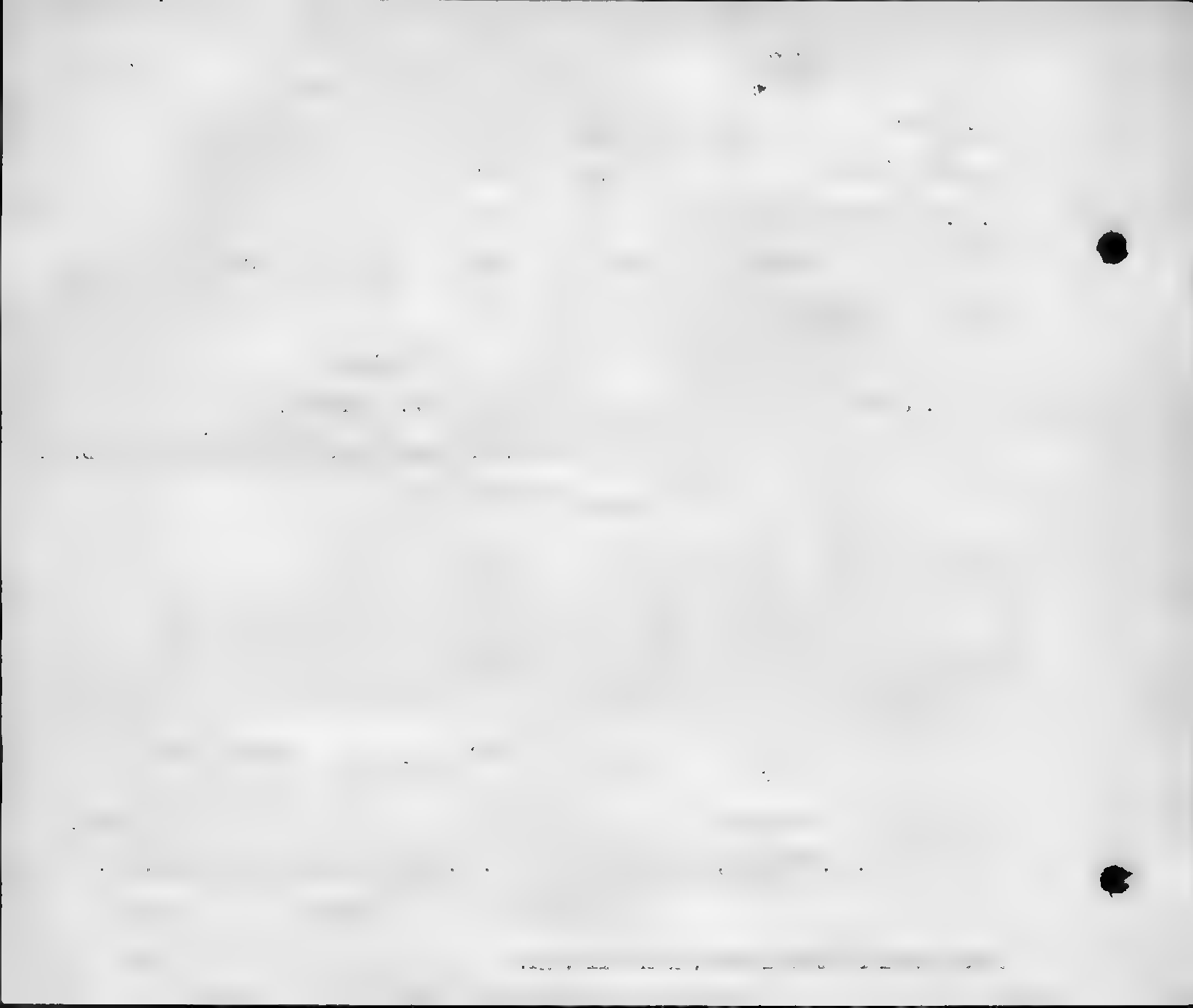




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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and must be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3292  
CERTIFICATE OF DEATH  
03280

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY (in days) <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>342A Eilers St.</b> d. STREET ADDRESS <b>March 7 1961</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David William JONES</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Country & State or foreign country) <b>California</b>
13. FATHER'S NAME <b>Gayl R. JONES</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn J. STRINGALL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(F) G. R. Jones, YN2, USN, Washington 25, D. C.</b>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma, disseminated</b> DUE TO <b>200-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 2 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>March 1, 1961</b> to <b>March 7, 1961</b> , that (X) (we) last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>8:20PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. A. PEARSON</b>		22b. DATE SIGNED <b>3-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. A. PEARSON, LCDR, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-10-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Rockville Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Tyson Wheeler Funeral Home, Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3293 CERTIFICATE OF DEATH 113281

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home</u>		d. STREET ADDRESS <u>10005 Rensselaer Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> (NMI) Middle <u>Jordens</u> Last <u>Jordens</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1877</u>
9. AGE (In years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining Camps</u>	
11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jordens</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stahr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs Roma Pettingill</u>		Address <u>10005 Rensselaer Rd. Md. Silver Sp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastases</u>			
1177X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1961</u> to <u>March 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 15, 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>		22b. DATE SIGNED <u>March 24, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRNS. &amp; BURIAL</u>		23b. DATE THEREOF <u>3/29/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>DENVER, COLORADO</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 28 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Walter E. Humphrey</u>	

M

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3294

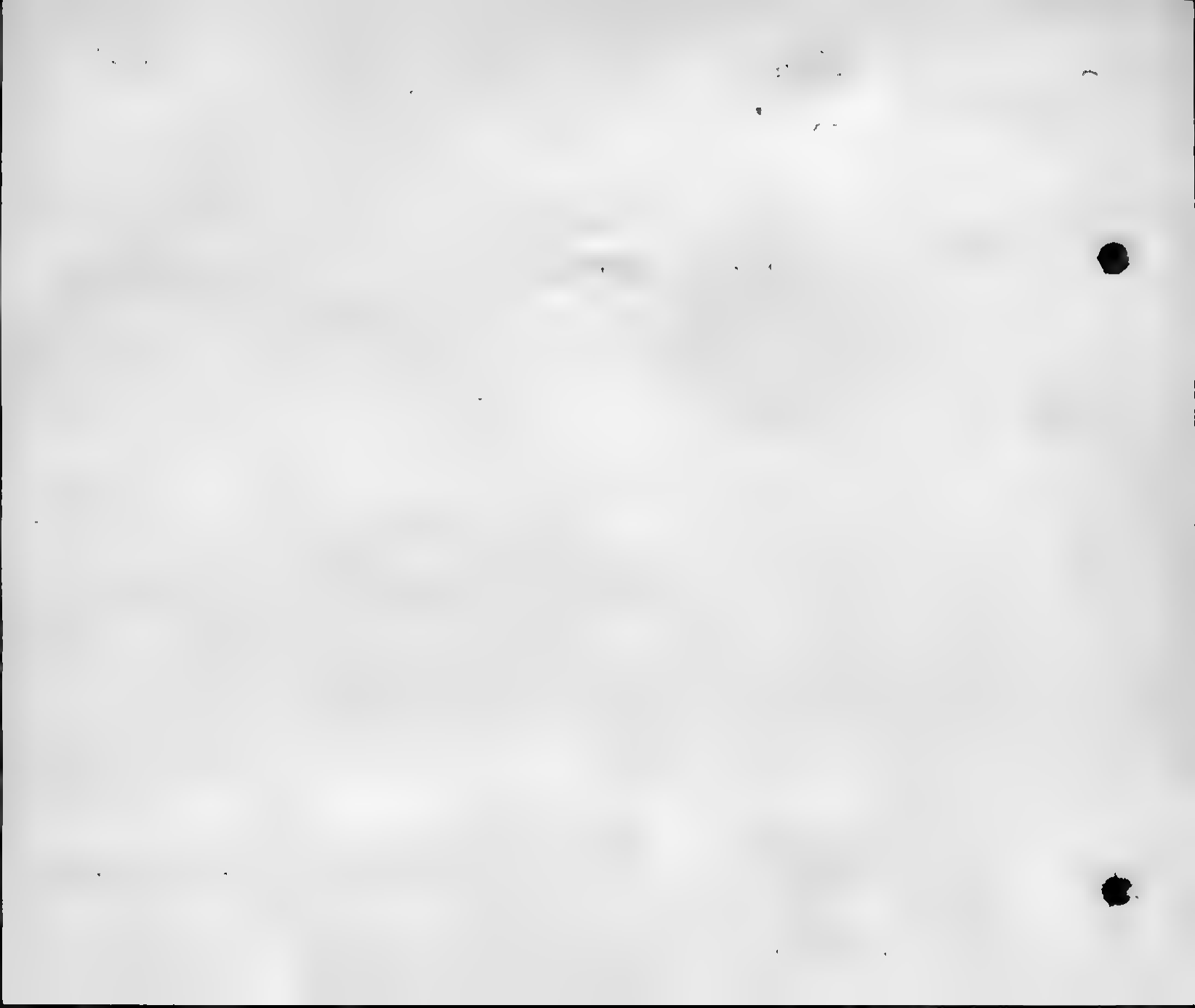
## CERTIFICATE OF DEATH

03282

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>17409 Ridgewood AVE</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Dorothy Constance Kampe</u>		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>25</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
<b>8. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>9. AGE</b> (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>WISCONSIN</u>			
<b>11. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>George D BRANDT</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Genevieve M. Frost</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>18. CAUSE OF DEATH</b> [Enter on y one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>155.8</u> DUE TO <u>Enema, Malnutrition, cachexia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cancer of abd cavity, recurrent</u> (c) <u>Cancer of colon removed in November (1961)</u> DUE TO <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 months</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)		<b>20c. TIME OF INJURY</b> Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>			
<b>20d. INJURY OCCURRED</b> Wh in el work <input type="checkbox"/> Not White at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office b dg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/9/1961</u> <b>to</b> <u>3/25/1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3/25/1961</u> <b>and that death occurred at</b> <u>5:10 A</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Charles H. Holahan MD</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/25/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Charles H. Holahan MD</u>		<b>22d. ADDRESS</b> <u>500 Underwood St. N. W. Wash. DC</u>		<b>23a. REC'D BY REGISTRAR</b> <b>23b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Haus</u>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>		<b>23d. LOCATION</b> (City town or county) (State) <u>Rockville, Maryland</u>		<b>23e. DATE THEREOF</b> <u>3/28/61</u>			
<b>23f. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23g. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>23h. ADDRESS</b> <u>Bethesda, Maryland</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

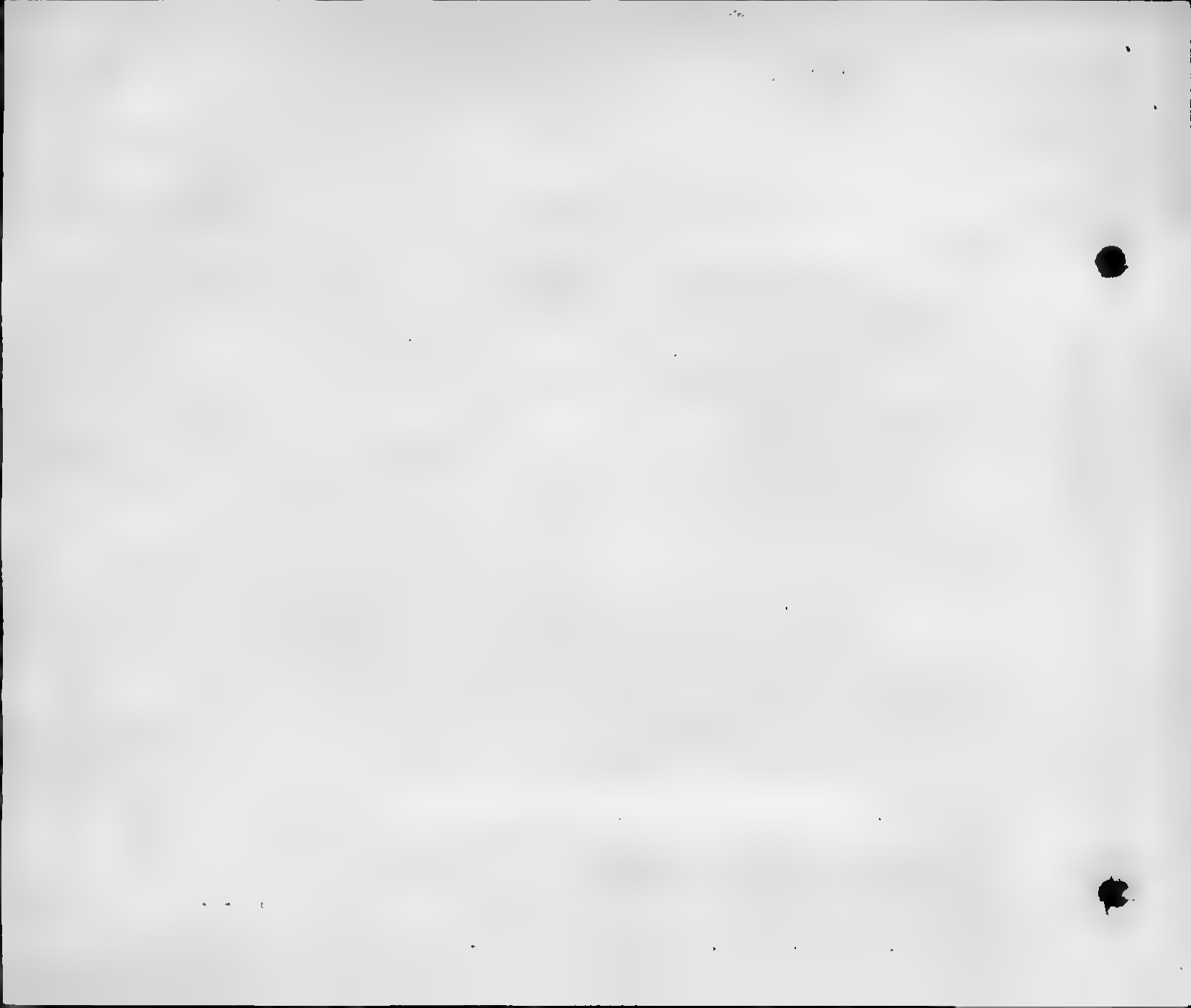
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03283

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>22 Manchester Place apt 304</u>		d. STREET ADDRESS <u>22 Manchester Pl. apt 304</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Kane</u>		4. DATE OF DEATH <u>Mar 28 1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 29 1897</u> 9. AGE (In years, last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>private home</u>		11. BIRTHPLACE (State or foreign country) <u>Estonia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Kane</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ruutel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>139-26-3537</u> 17. INFORMANT <u>Vali Ksenia</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardio-renal disease</u> (c) <u>Cardio-renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>3</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brozant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brozant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-28-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/30/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR <u>WARNER E. BUMPNEY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REGISTERED BY REGISTRAR <u>Arthur S. Kraus</u> 24b. REGISTRAR'S SIGNATURE	





may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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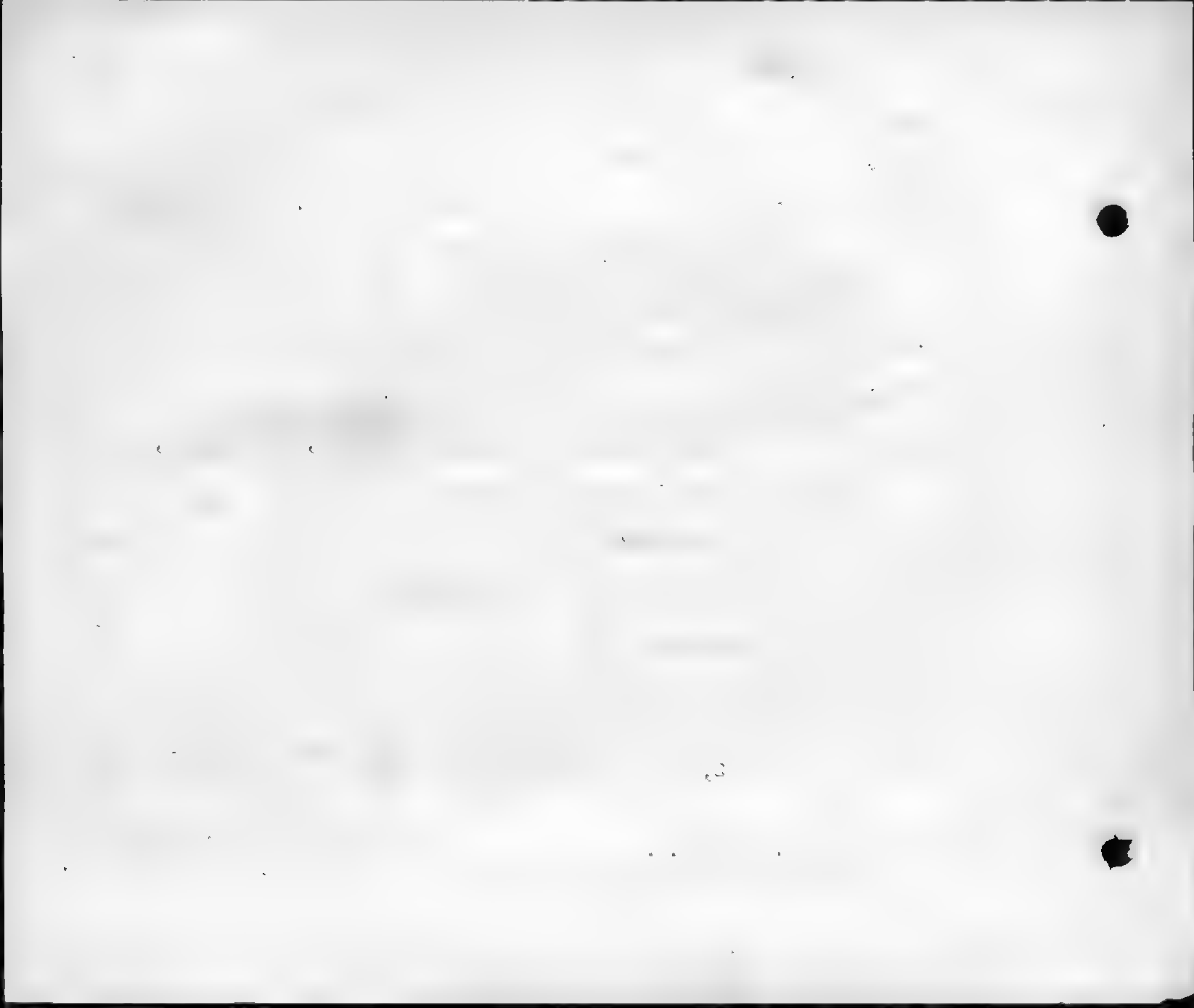
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3296

CERTIFICATE OF DEATH

03284

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>New York</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>58 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>				d. STREET ADDRESS <b>218-40 82nd Ave. (Queens Village)</b>			
3. NAME OF DECEASED (Type or print) First <b>Isidore</b> Middle <b>(None)</b> Last <b>Kassman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 2, 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fur Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Mordechai Kassman</b>				14. MOTHER'S MAIDEN NAME <b>Emma Feldman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Not Available</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra Peritoneal hemorrhage</b> DUE TO <b>Thrombocytopenia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Reticulum Cell sarcoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>20 Hours</b> <b>4 Months</b> <b>3 Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>January 3, 1961</b> to <b>March 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 2, 1961</b> , and that death occurred at <b>1:00 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Martin J. Cline</b> M.D.				22b. DATE SIGNED <b>3/2/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Martin J. Cline M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ELMONT L.I. N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danganby &amp; Sons</b> ADDRESS <b>3501-14th St NW</b>				25a. REC'D BY REGISTRAR <b>MAR 6 '61</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



3297

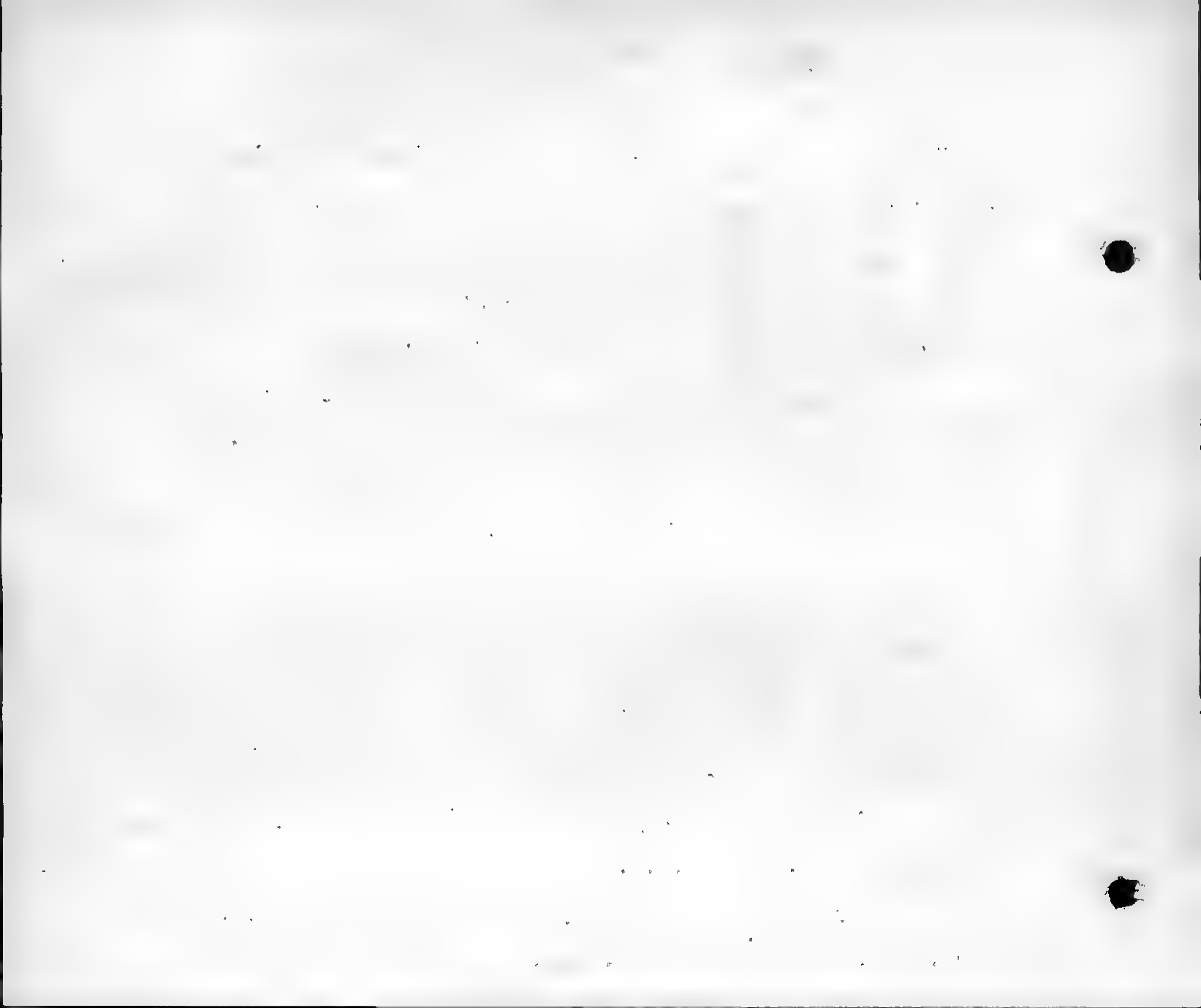
CERTIFICATE OF DEATH

Reg. Dist. No. 03285

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton (Silver Spring)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12608 Valley Wood Drive</b>		d. STREET ADDRESS <b>12608 Valley Wood Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>A</b> Last <b>KELEHER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1867</b>
9. AGE (In years last birthday) <b>93</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b> Hours <b>48</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Entomologist-Dept. of Agrct</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Keleher</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Trunnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>A</b> INFORMANT Address <b>Mary Theresa Motley-#2d.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured of arteries clotted aneurysm of abdominal aorta</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>approx. 10-20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <b>March</b> Day <b>9</b> Year <b>1961</b> Hour <b>a. m.</b> <b>11:15</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 9, 1957</b> to <b>March 9, 1961</b> , that I last saw the deceased alive on <b>March 9, 1961</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph F. Patton</b> M.D.		ADDRESS (Street, city or town, state) <b>8641-Colesville Road</b> DATE SIGNED <b>March 9, 1961</b>	
PHYSICIAN'S NAME (Type) <b>Ralph F. Patton, M.D.</b>		<b>8641-Colesville Road Silver Spring, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-11-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Ryan, Inc.</b> ADDRESS <b>317 Penna. Ave., SE</b>		24. REC'D BY REGISTRAR <b>MAR 13 '61</b> 24b. REGISTRAR'S SIGNATURE <b>C. L. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3298

## CERTIFICATE OF DEATH

Reg. Dist. No. 03286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Archer-Woodland Nursing Home</u>				d. STREET ADDRESS <u>8813 Glenville Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>ROSE ALICE KERR</u>				4. DATE OF DEATH <u>MARCH 25 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-11-69</u>	
9. AGE (In years last birthday) <u>92</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Andrew J. Paddock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lauck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Horace J. Kerr</u> Address <u>8813 Glenville Rd S.S.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic vascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 1959</u> to <u>3/25 1961</u> , that I last saw the deceased alive on <u>3/24 1961</u> , and that death occurred at <u>3:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>A. F. Thibadeau</u> M.D. <u>1011 COLESVILLE RD</u>				PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU</u> <u>SILVER SPRING, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>		22d. LOCATION (City, town, or county) <u>Penna.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga Ave NW</u>				24a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



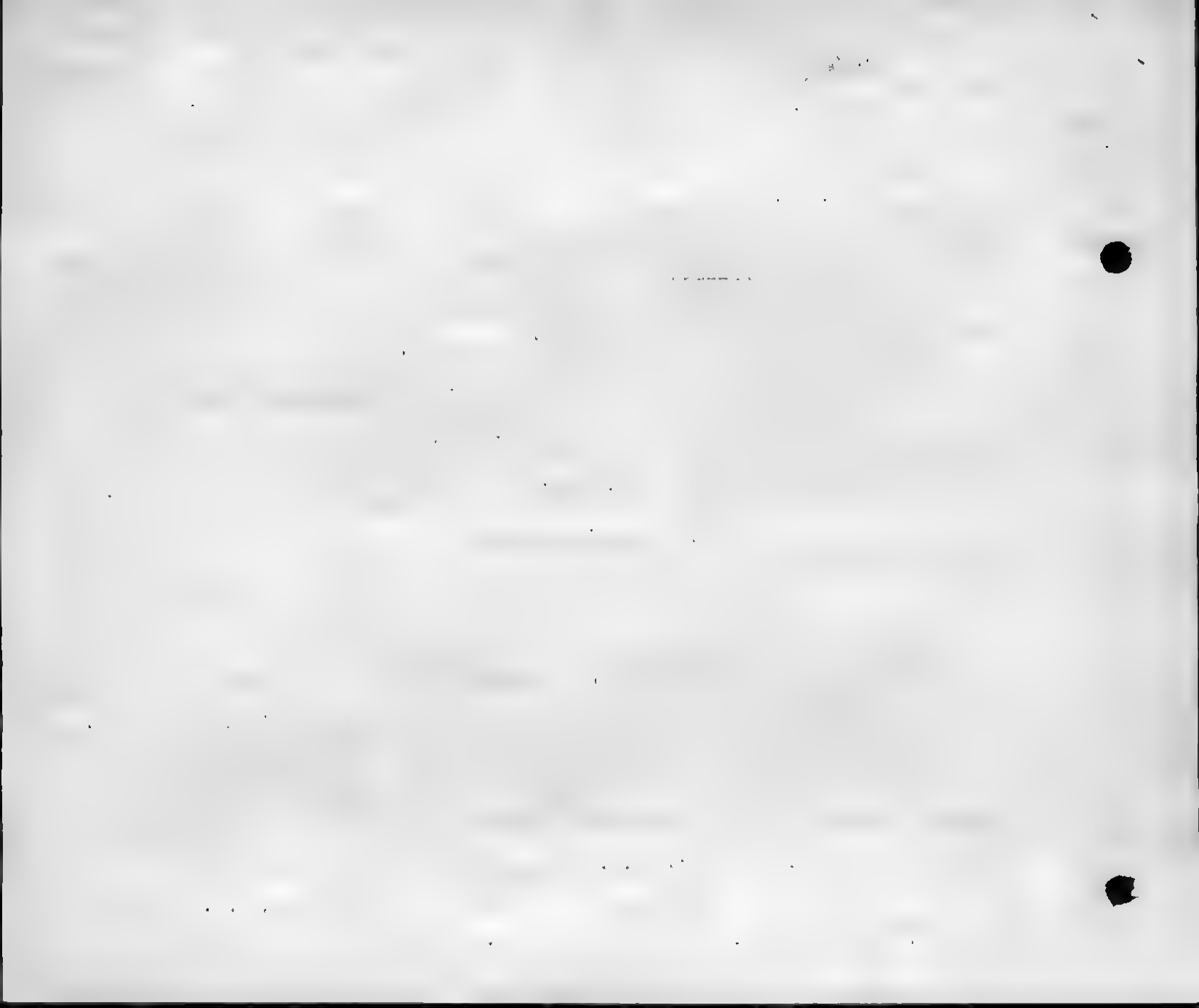
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FOR STATE  
HEALTH DEPT.  
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TO PROPERTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 should be executed by a funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03287

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 8505 14th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Gertrude Klindworth		4. DATE OF DEATH Month Day Year 3 13 1961			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/30/92		9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 16 1 15	
10a. USUAL OCCUPATION (Give kind of work, including working if a, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Reymer's Candy Co.		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Anton Riester		14. MOTHER'S MAIDEN NAME Elizabeth <del>Reymer</del> Ochsenhirt		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Hospital records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis 103.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of right patella DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden 15 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) reported fell on pavement on front of her home 20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 p.m. 2/26/61 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) home 20f. (City or town) (County) (State) Hyattsville, PG Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/14/61	
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/16/61	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR RAYMER E. PUMPHREY, INC. Raymond E. Pumphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR MAR 20 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
3300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adelphi</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1673-2</u> d. STREET ADDRESS <u>10406 Truxton Road</u>	
3. NAME OF DECEASED (Type or print) <u>Patricia Anna Kline</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>3</u> Day <u>21</u> Year <u>41</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Kline</u>		14. MOTHER'S MAIDEN NAME <u>Anna V. Nelma</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-38-1517</u>	
17. INFORMANT <u>Hospital Admitting Record</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspirin poisoning</u> DUE TO (b) <u>970.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Reported to have taken 100-572 Aspirin Tab.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>Reported to have taken 100-572 Aspirin Tab.</u>	
21. TIME OF INJURY Month, Day, Year <u>2:30 PM 3-12-1961</u>		22. INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> b. CITY OR TOWN (County) <u>Adelphi P.G.</u> (State) <u>MD</u>	
23. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. CHIEF MEDICAL EXAMINER <u>Frank J. Broschert</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>3-12-61</u>	
25. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		26. DATE THEREOF <u>3-16-1961</u>	
27. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		28. LOCATION (City, town, or county) (State) <u>FT MYER VA.</u>	
29. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.</u>		30. RIVERDALE, MD.	
31. REC'D BY REGISTRAR <u>MAR 15 '61</u>		32. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



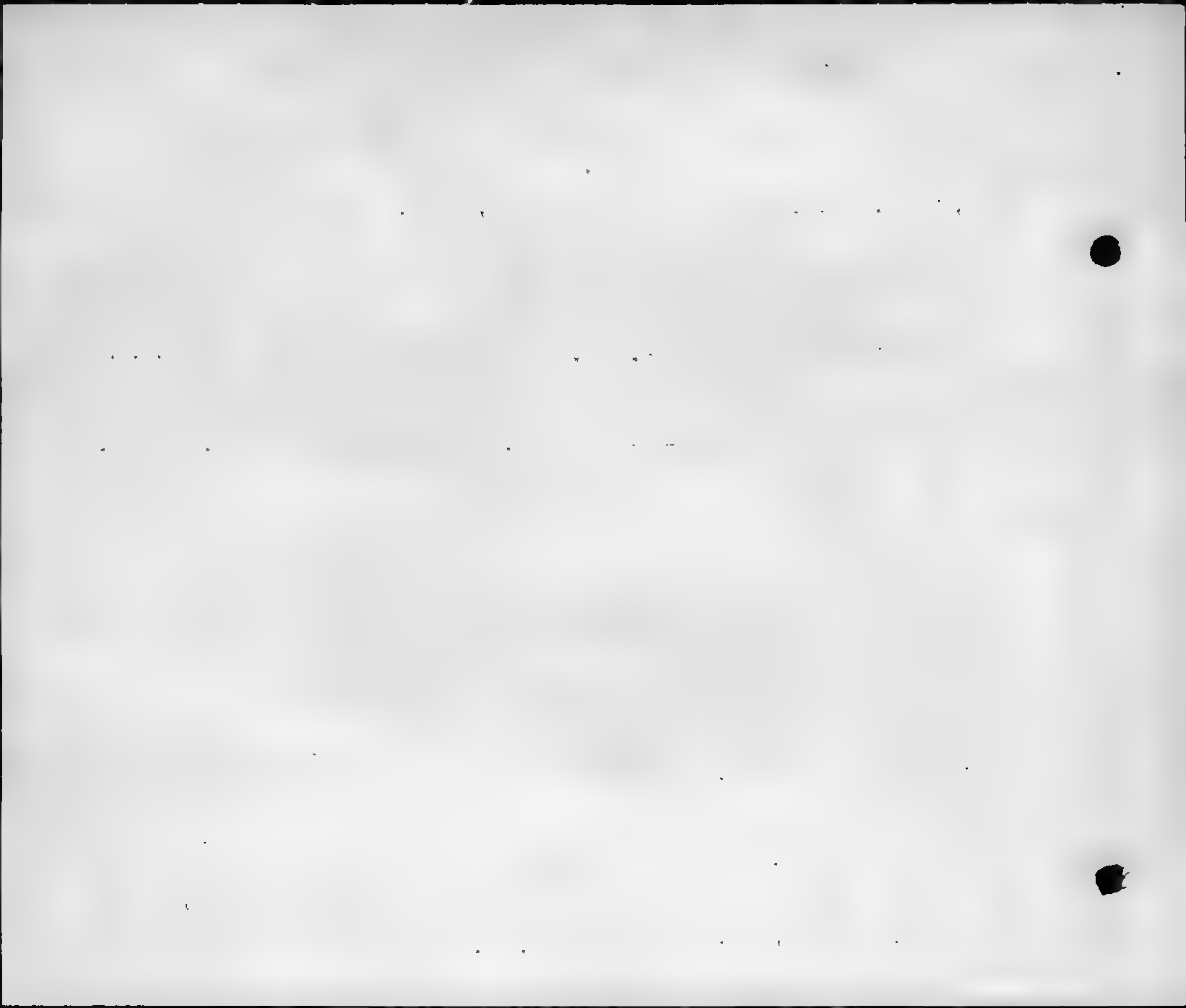
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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03289

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN IL <b>5 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10,723 St. Paul Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>10,723 ST. PAUL STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDGAR (NMI) KRAHN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/1/94</b>	
9. AGE (in years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mathematician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Ord. Lab.</b>	
11. BIRTHPLACE (State or foreign country) <b>Lais, Estonia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August Krahn</b>		14. MOTHER'S MAIDEN NAME <b>Helene Freund</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-34-5461</b>	
17. INFORMANT <b>Mrs. Dorothee Krahn</b>		Address <b>10723 St. Paul St. Kensington</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> <b>Coronary occlusion</b> DUE TO cause last. (c) <b>420.1</b> <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>History of previous heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/6/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/9/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR <b>WALTER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>MAR 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krahn</b>	



TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please place the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

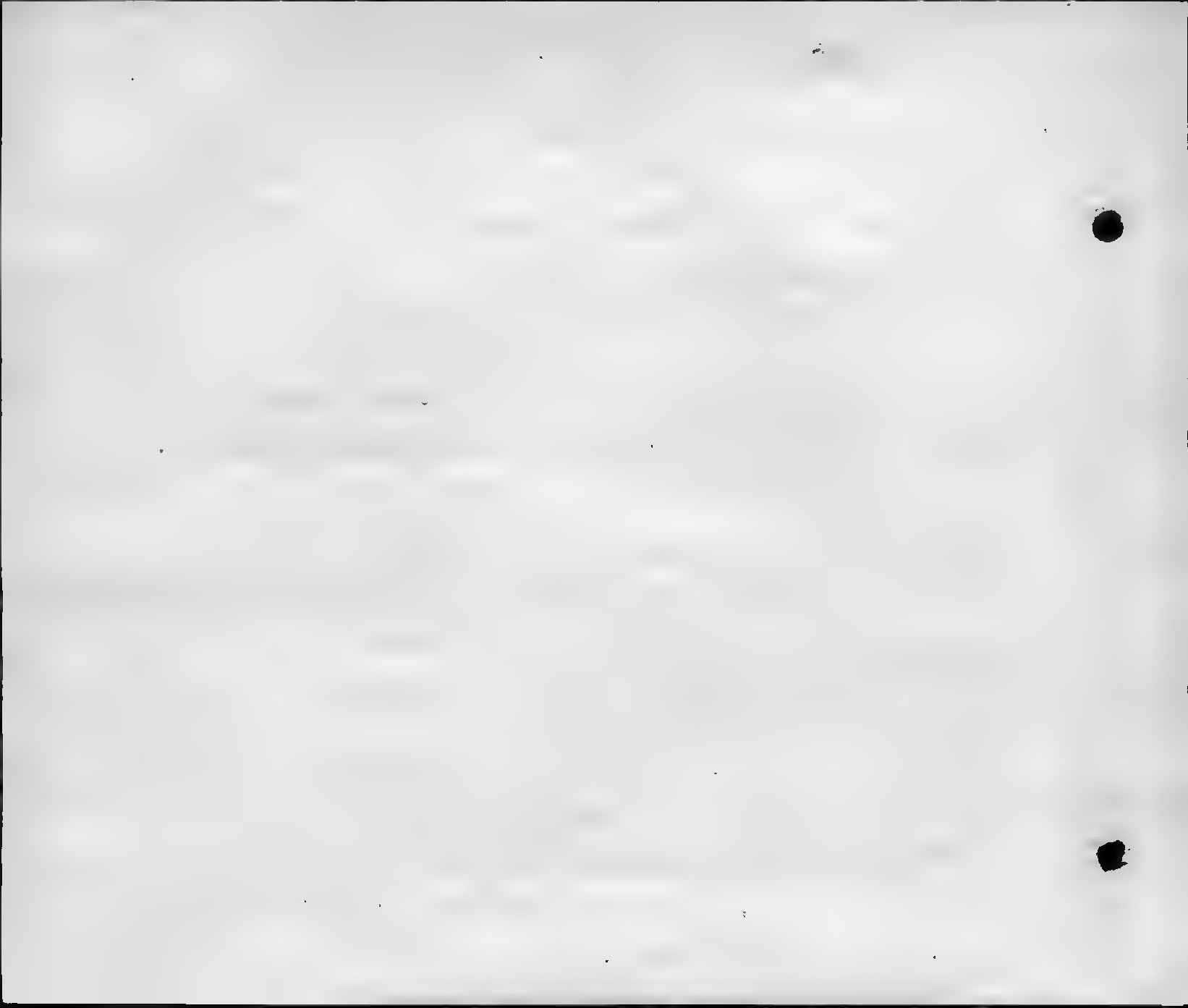
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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03294									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P. G.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				
c. LENGTH OF STAY IN b. <u>1/2 hr.</u>					d. STREET ADDRESS <u>2013 Lewisdale Dr</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11105 Bucknell Dr</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Joseph John Kroto</u>					4. DATE OF DEATH <u>Mar 18 1961</u>				
5. SEX <u>Male</u>					6. DATE OF BIRTH <u>9-7-05</u>				
6. COLOR OR RACE <u>White</u>					7. AGE (In years last birthday) <u>55</u> yrs.				
7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>				
11. BIRTHPLACE (State or foreign country) <u>Ta</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Anthony Kroto</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Svuba</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) <u>Yes</u> <u>WW II</u>					16. SOCIAL SECURITY NO. <u>213 34 3509</u>				
17. INFORMANT <u>Mrs Tillie Kroto Hyattsville Md.</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-20-1</u> DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
NAME (Type) <u>FRANK J. Brosch</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>March 22, 1961</u>				
22c. NAME OF CEMETERY OR BURIAL PLACE <u>Arlington National</u>					22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>				
23. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md;</u>					24a. REC'D BY REG STRAR <u>MAR 22 '61</u>				
ADDRESS					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3303

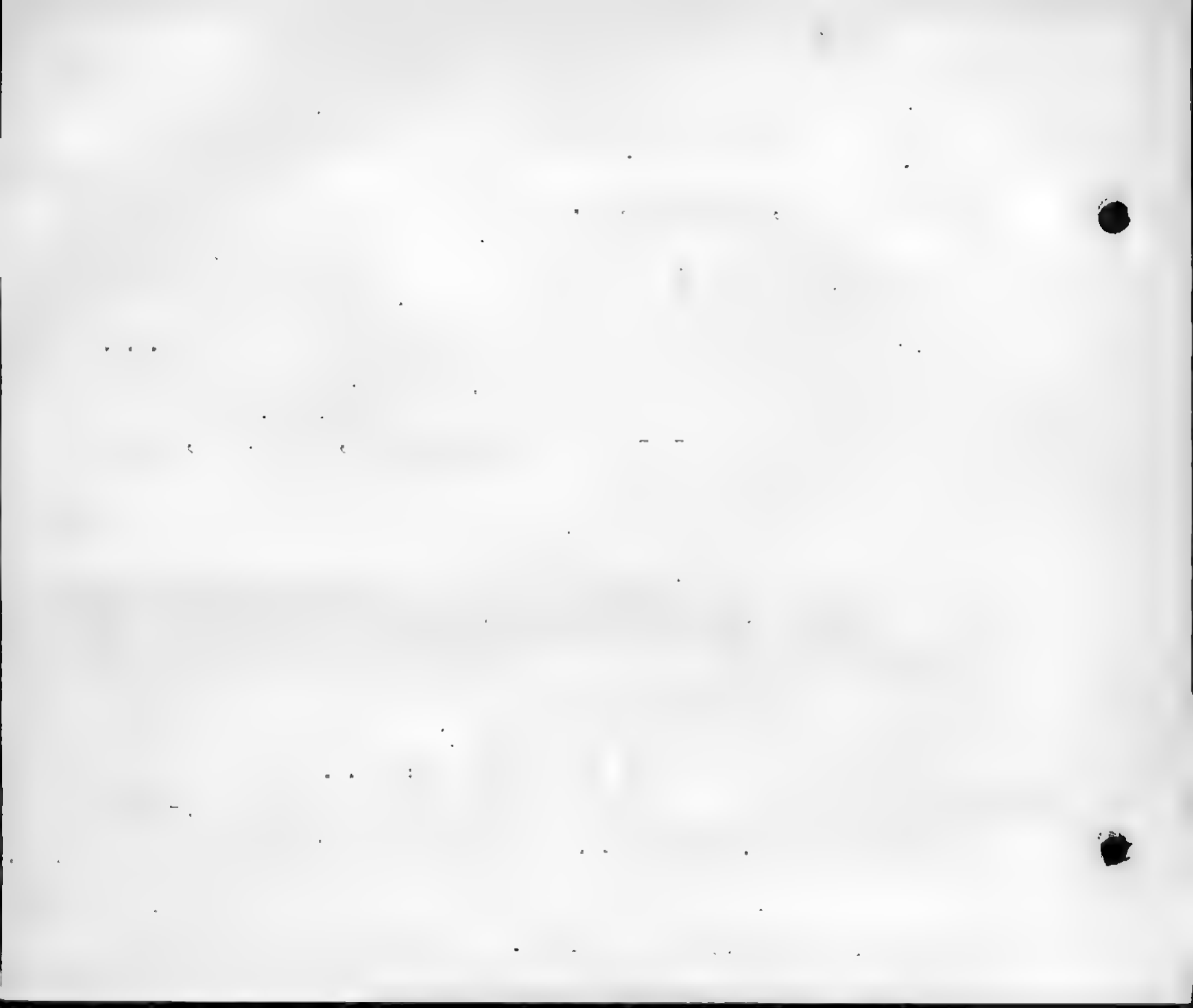
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 2, 3, & 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

03291

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Alverda</b>	
c. LENGTH OF STAY IN 1b <b>23 Days</b>		d. STREET ADDRESS <b>Box #6</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anthony</b> Middle <b>Robert</b> Last <b>Landi</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 26, 1912</b>
9. AGE (In years last birthday) <b>49 yrs</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b> Hours <b>10</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Victor Landi</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Pagni</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>194-01-6281</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO (b) <b>Rheumatic Heart Disease with</b>			
DUE TO (c) <b>Mitral Insufficiency</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Surgery, Replacement of Mitral Valve</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>February 13 1961</b> to <b>March 8 1961</b> that (b) (we) last saw the deceased alive on <b>March 8 1961</b> and that death occurred <b>10:25 A. M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Benson R. Wilcox M.D.</b>		22b. DATE SIGNED <b>3-9-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>BENSON R. WILCOX, M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial-transit 3-9-61</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Nicktown Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Nicktown, Pennsylvania</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

1

# CERTIFICATE OF DEATH

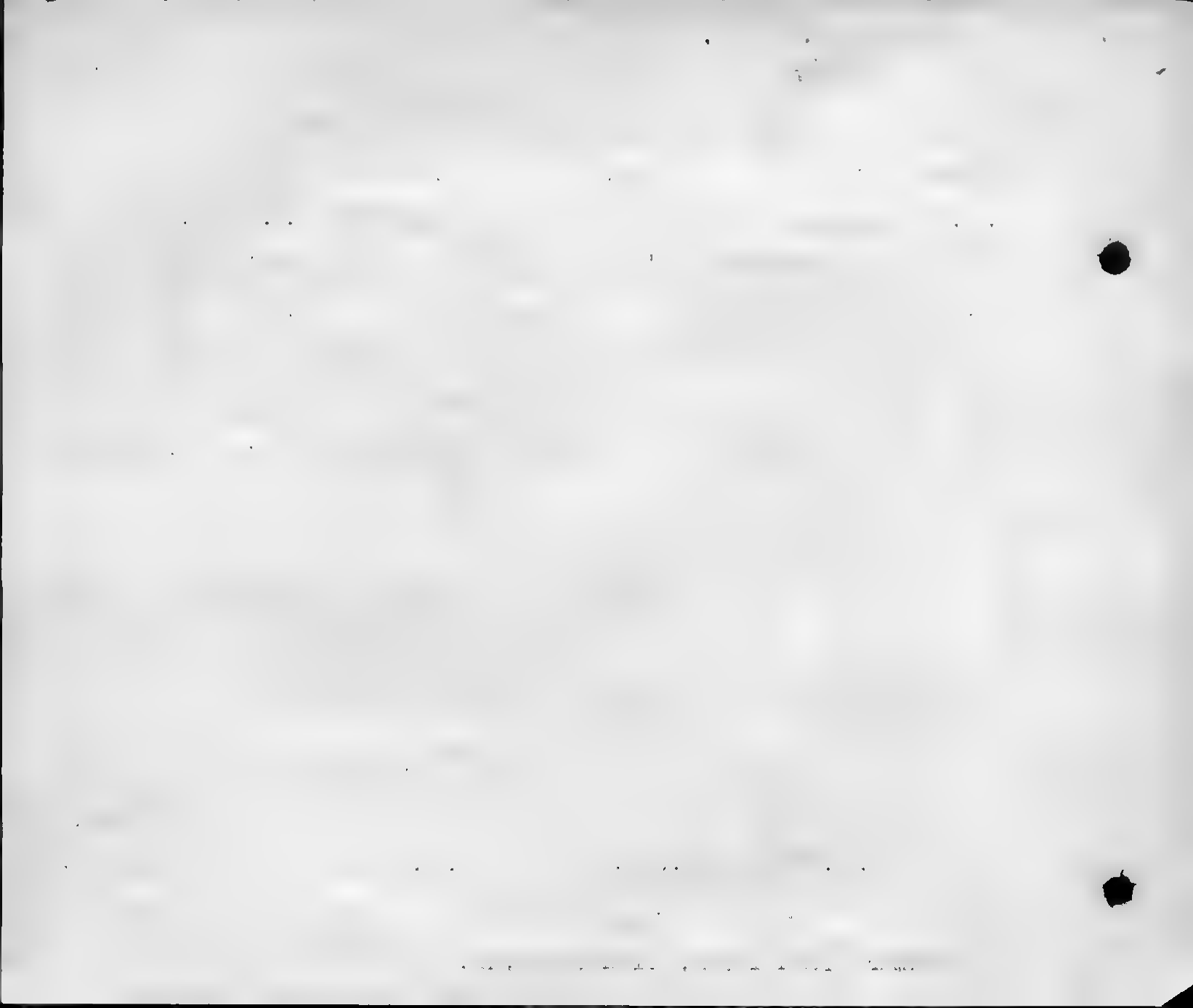
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3304

## CERTIFICATE OF DEATH

03292

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Montgomery</u> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> <b>c. LENGTH OF STAY</b> (If not in hospital, give street address) <u>119 days</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) <b>a. STATE</b> <u>MARYLAND</u> <b>b. COUNTY</b> <u>District of Columbia</u> <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <b>d. STREET ADDRESS</b> <u>1763 Columbia Rd., N.W. - Apt. 51</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>First</b> <u>Florence</u> <b>Middle</b> <u>O'Toole</u> <b>Last</b> <u>LANE</u> <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-22-93</u> <b>9. AGE</b> (In years) (If under 1 year, last birthday) <u>67</u> <b>Months</b> <u>15</u> <b>Days</b> <u>15</u> <b>Hours</b> <u>1961</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Massachusetts</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas E. O'Toole</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>(S) R. I. Lane, 1710 Glenkarney Pl., SS, Md.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Brown</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>ADENOCARCINOMA, COLON</u> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b)</b> <u>153.8</u> <b>(c) DUE TO</b> <b>PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>ARTERIO-SCLEROTIC HEART DISEASE</u> <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>21. I certify that</b> (If this hospital attended the deceased from <u>Nov. 16, 1960</u> to <u>March 15, 1961</u> , that (X) (we) last saw the deceased alive on <u>March 15, 1961</u> , and that death occurred at <u>8:10 PM</u> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>[Signature]</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>DR. RYSKAMP, JR., LT, MC, USN</u>		<b>22b. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3-20-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington Virginia</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Ziska</u> <b>25a. REC'D BY REGISTRAR</b> <u>MAR 21 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Thomas</u>		<b>26. ADDRESS</b> <u>W. E. Humphrey Funeral Home, Silver Spring, Md.</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

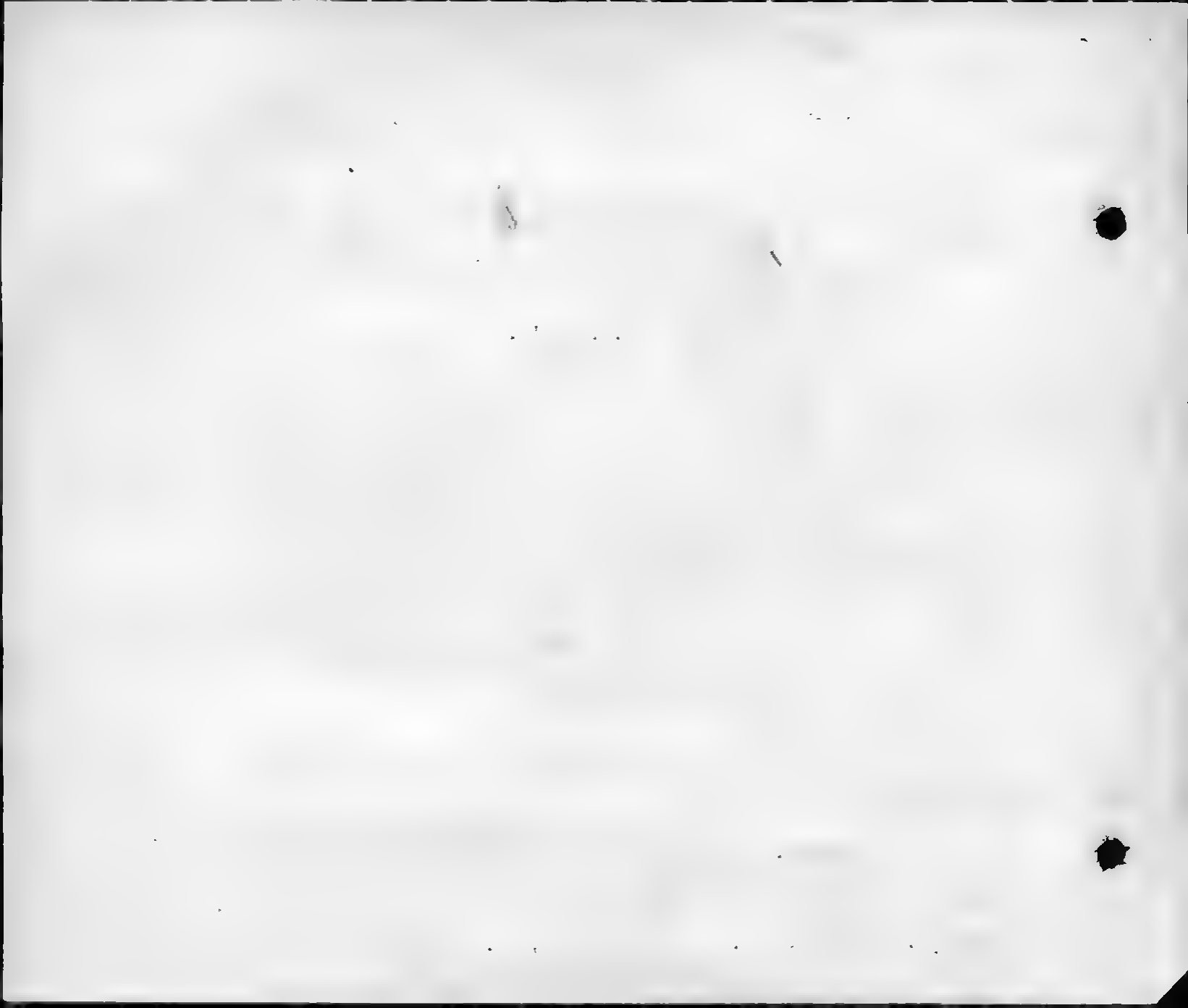


3305

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03293

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN lb <b>15 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanatorium &amp; Hospital</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> <b>16.5</b> d. STREET ADDRESS <b>7402 Wildwood Dr</b>											
3. NAME OF DECEASED (Type or print) <b>Philip Lett HECKEY</b>		4. DATE OF DEATH Month <b>3</b> Day <b>16</b> Year <b>1961</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25</b> / <b>7</b> - <b>1907</b>		9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt City Post Office</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>			
13. FATHER'S NAME <b>Samuel Rutherford Murrex Heckey</b>						14. MOTHER'S MAIDEN NAME <b>Edith Locher</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Hospital Records</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction - Rupture, and tamponade</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b> <b>15 hrs -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <b>July 1956</b> to <b>March 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1961</b> , and that death occurred on <b>5 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>James M. Whitlock</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <b>3-16-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>JAMES M. WHITLOCK</b>				22d. ADDRESS <b>7717 Canoll Ave Takoma Park Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>3/18/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Loudon County, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC.</b> <b>Raymond W. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 21 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3306

## CERTIFICATE OF DEATH

03294

### 1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (Outside of corporate limits, write RURAL and give nearest town)

TAKOMA PARK

c. LENGTH OF STAY IN 1b

2 hrs 45 min

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington San. & Hospital

### 3. NAME OF DECEASED

(Type or print)

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

3/18/91

### 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington D.C.

d. STREET ADDRESS

3623 Aiton Place N.W.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

### 4. DATE OF DEATH

Month

Day

Year

MARCH 25 1961

9. AGE (In years last birthday)

70 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Theatre Owner

11. BIRTHPLACE (County & State or foreign country)

Mississippi

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

LOUIS LEHMANN

14. MOTHER'S MAIDEN NAME

LENA LEHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital Record

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Myocardial Infarction

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Arteriosclerotic Cardiovascular Disease

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m. p.m.

19

Where of work

Not White of work

21. I certify that (I) (the physician) attended the deceased from March 18, 1961 to March 25, 1961, that (I) (the) last saw the deceased alive on March 25, 1961, and that death occurred at 10:30 p.m. from the causes and on the date stated above.

22a. SIGNATURE

Paul Eanet

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

3-25-61

22c. PHYSICIAN'S NAME (Type)

PAUL EANET

22d. ADDRESS

6727-16th St. N.W. WASH. DC

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

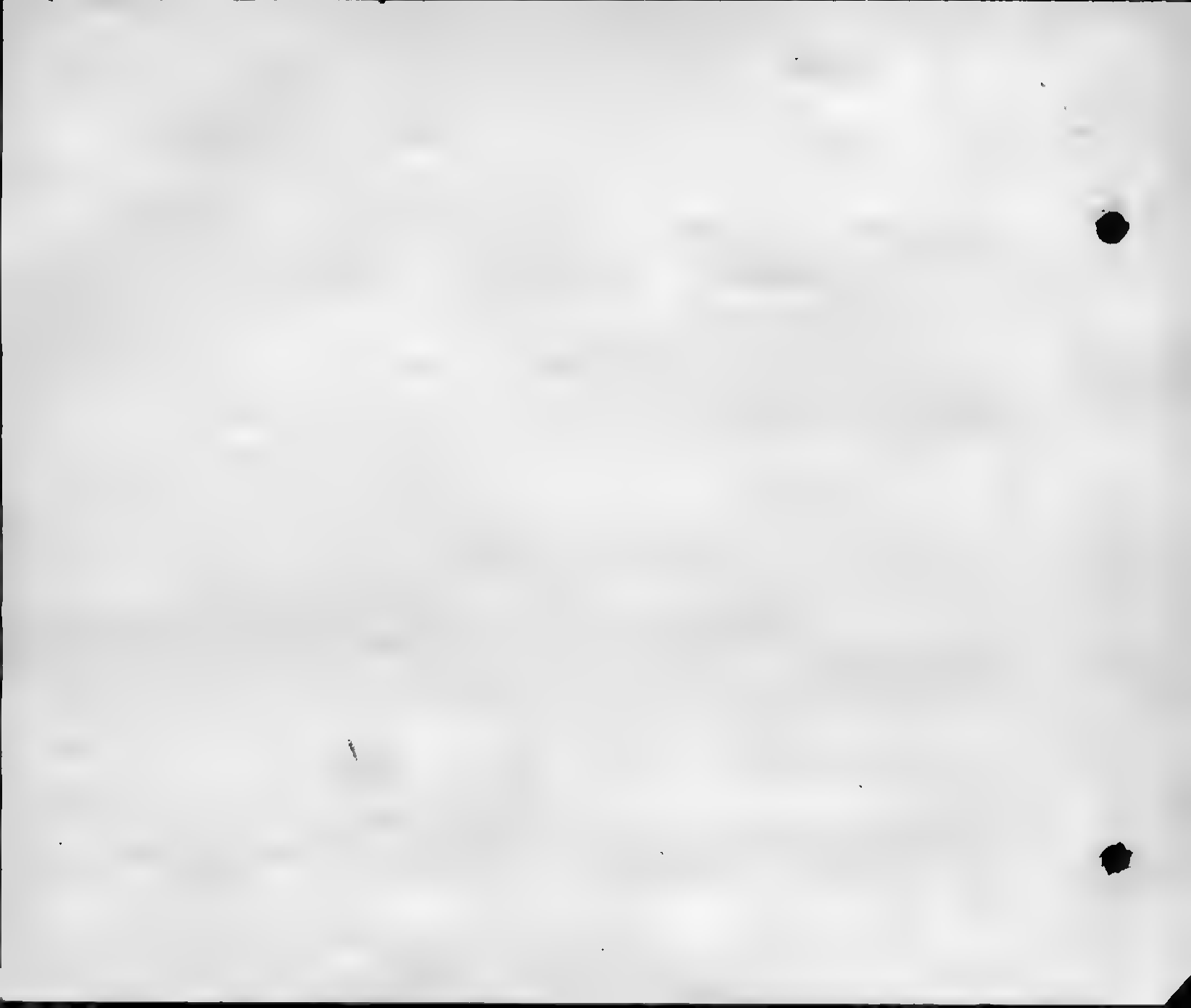
Heal Funeral Home 4812 Gleason Rd Wash DC

MAR 27 '61

Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03295

1  
FOR STATE HEALTH DEPT.  
M  
X  
I  
TO DETECT MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u> 4 km</p> <p>c. LENGTH OF STAY IN b. <u>4 km</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.E.P. Co. Generation Station</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u></p> <p>d. STREET ADDRESS <u>6943 Decatur St</u></p>			
<p>3. NAME OF (Type or print) <u>Frank Andrew Lesko</u></p> <p>First Middle Last</p>				<p>4. DATE OF DEATH <u>March 10 1961</u></p> <p>Month Day Year</p>			
<p>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 31 - 1918</u></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>				<p>9. AGE (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber Construction</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>Pa.</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>			
<p>13. FATHER'S NAME <u>Andrew Lesko - 577-10-7641</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Robertson Bonerian</u></p> <p>16. SOCIAL SECURITY NO. <u>700-200000-1000</u></p> <p>17. INFORMANT <u>Tom Caton - P.E.P. Co.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u></p> <p>420.1 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <u>Frank J. Blaschke</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>EXAMINER'S NAME (Type) <u>FRANK J. BLASCHKE</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-10-61</u></p> <p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>March 15, 1961</u> 22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u> 22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u></p> <p>23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 24a. REC'D BY REGISTRAR <u>MAR 16 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u></p>							





may be obtained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3308

03296

1. PLACE OF DEATH a. COUNTY <b>MONTG.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b>		c. LENGTH OF STAY IN 1b <b>1 MOS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING HOME</b>				d. STREET ADDRESS <b>3500 - O St. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <b>BELLA</b> First Middle Last (Type or print)				4. DATE OF DEATH <b>MARCH 21 - 1961</b> Month Day Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-1-1893</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>578-48-5456</b>		17. INFORMANT <b>SAMUEL LEVIN</b>		Address <b>3500 - O - N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>32X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease, mitral stenosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 weeks</b>  <b>4 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o m. p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1952</b> to <b>3/21</b> , 1961, that (I) (we) last saw the deceased alive on <b>3/21</b> 1961, and that death occurred at <b>9:45</b> P.M. from the causes and on the date stated above							
22a. SIGNATURE <b>Irving W. Winik</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/21/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Irving W. Winik</b>		22d. ADDRESS <b>3900 McKinley St. N.W.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Hyattsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Georgie Green Home</b>		ADDRESS <b>4217-9th St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

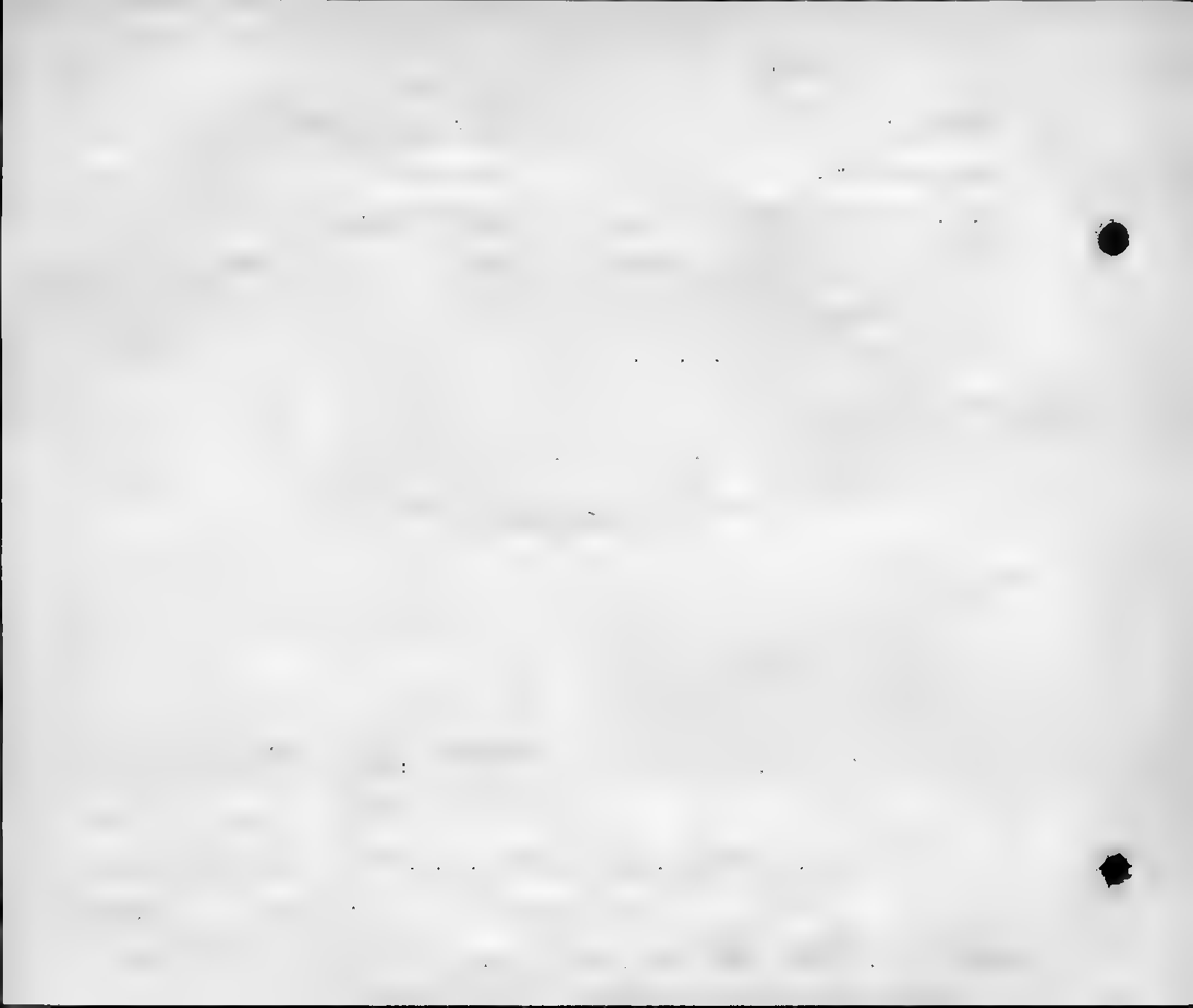


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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M  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3309  
CERTIFICATE OF DEATH  
03297

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1804 28th Street, S. E.</b> d. STREET ADDRESS <b>1804 28th Street, S. E.</b>	
3. NAME OF DECEASED (Type or print) <b>John Mathew LIESCH</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-17-87</b>	
9. AGE (in years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>3</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob LIESCH</b>		14. MOTHER'S MAIDEN NAME <b>Emila BRASOLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>adenocarcinoma, liver, with metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <b>March 15, 1961</b> to <b>March 20, 1961</b> , that (s) (we) last saw the deceased alive on <b>March 20, 1961</b> , and that death occurred at <b>6:50AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul G. Linaweaver</b>		22b. DATE SIGNED <b>3-20-61</b>	
22c. PHYSICIAN'S NAME (Type or print) <b>Paul G. LINAWEAVER, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros. Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 23 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

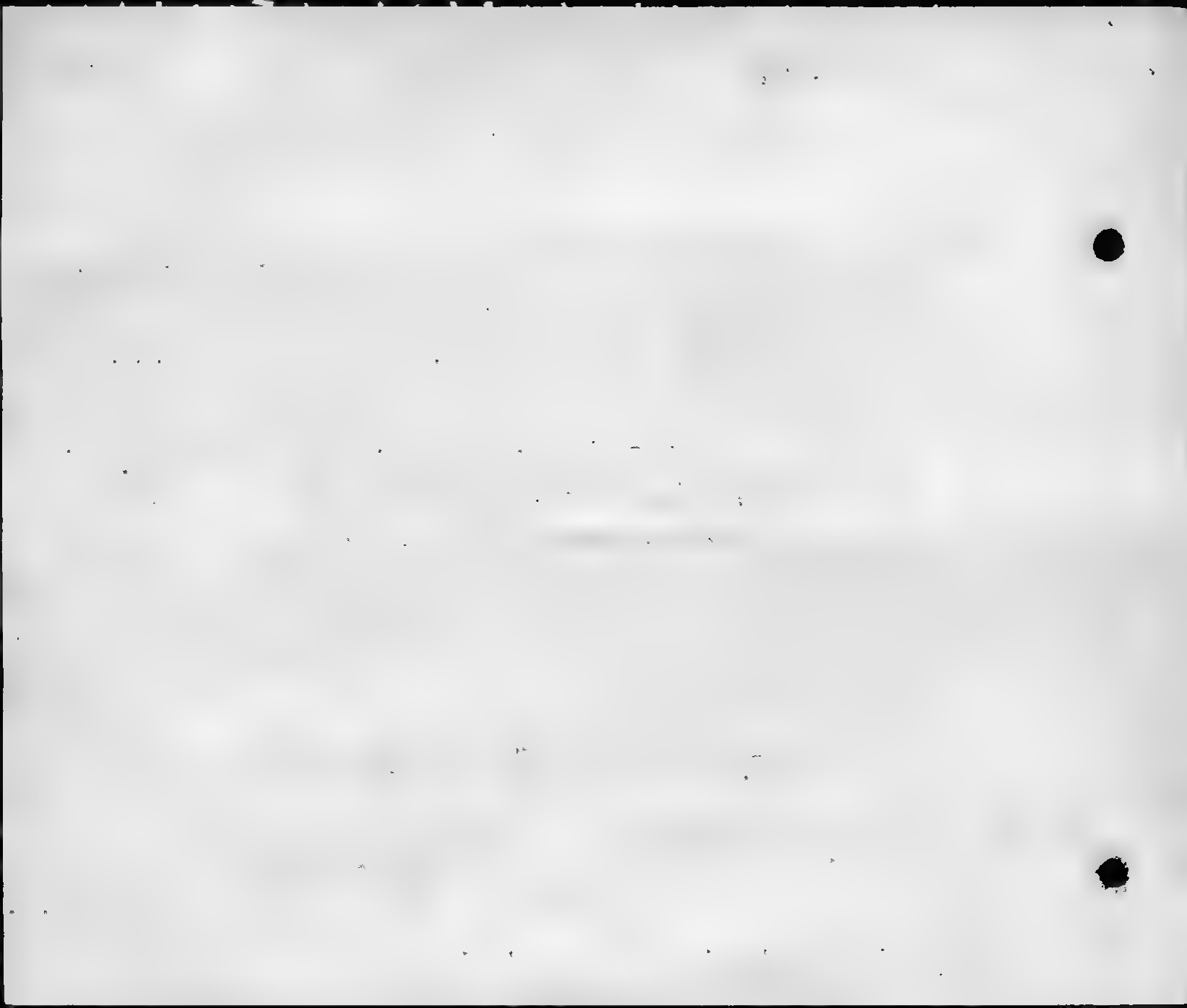
VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3310

03298

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> (M) <u>Montgomery</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) <b>a. STATE</b> <u>Maryland</u>		<b>b. COUNTY</b> <u>Montgomery</u>	
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		<b>c. LENGTH OF STAY IN 1b</b> <u>DOA</u>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Preston Brooks Longley</u>		<b>4. DATE OF DEATH</b> Month <u>Mar.</u> Day <u>5</u> Year <u>1961</u>		<b>15. RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>3/12/06</u>		<b>9. AGE</b> (In years, last birthday) <u>54</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>1</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Greene, Maine</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Willis Longley</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lillian Brooks</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-01-9148</u>		<b>17. INFORMANT</b> Address <u>Mrs. Adrienne J. Longley, 312 Southwest Dr. Silver Spring, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Insufficiency</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 30-40 min.</u> <u>5-6 yrs.</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Apr. 1946</u> <b>to</b> <u>5 Mar. 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 20, 1961</u> , <b>and that death occurred at</b> <u>11:30 A.M.</u> <b>from the causes and on the date stated above</b>					
<b>22a. SIGNATURE</b> <u>M. B. Queen</u>		<b>22b. DATE SIGNED</b> <u>3/6/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M. B. QUEEN</u>	
<b>22d. ADDRESS</b> <u>7112 Willow Ave Takoma Park, Md.</u>		<b>22e. REC'D BY REGISTRAR</b> DATE <u>MAR 9 '61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3/8/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Darnestown Presbyterian Church Cemetery</u>	
<b>23d. LOCATION</b> (City, town or county) (State) <u>Darnestown Montgomery Co. Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. Stuart L. Hanna</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Pomphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3311  
CERTIFICATE OF DEATH  
03299

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>220 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>3412 S. Stafford</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Jones</u> First Middle 4. DATE OF DEATH <u>March 23 19 61</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-15-22</u> 9. AGE (In years if UNDER 1 YEAR, last birthday; Months if UNDER 24 HRS., Days; Hours; Min) <u>39</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Marine Corps</u> 11. BIRTHPLACE (County & State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry MARSH</u> 14. MOTHER'S MAIDEN NAME <u>Mae JONES</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1940 to DOD</u> 16. SOCIAL SECURITY NO. <u>272-18-8564</u> 17. INFORMANT <u>(W) Mrs. Zoe A. Marsh, same as #2 above</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>7-8 mos</u> DUE TO (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7-8 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <del>he</del> (this hospital) attended the deceased from <u>Aug. 15</u> , 19 <u>60</u> , to <u>March 23</u> , 19 <u>61</u> , that <del>he</del> (we) last saw the deceased alive on <u>March 23</u> , 19 <u>61</u> , and that death occurred at <u>3P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Larry J. Hines</u> M.D. 22b. DATE SIGNED <u>3-24-61</u> 22c. PHYSICIAN'S NAME (Type) <u>Larry J. HINES, CDR, MC, USN</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>3-25-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u> 23d. LOCATION (City, town or county) <u>Washington, D. C.</u> (State)		25a. REC'D BY REGISTRAR <u>MAR 28 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>1400 Chapin St., NW, WashDC</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

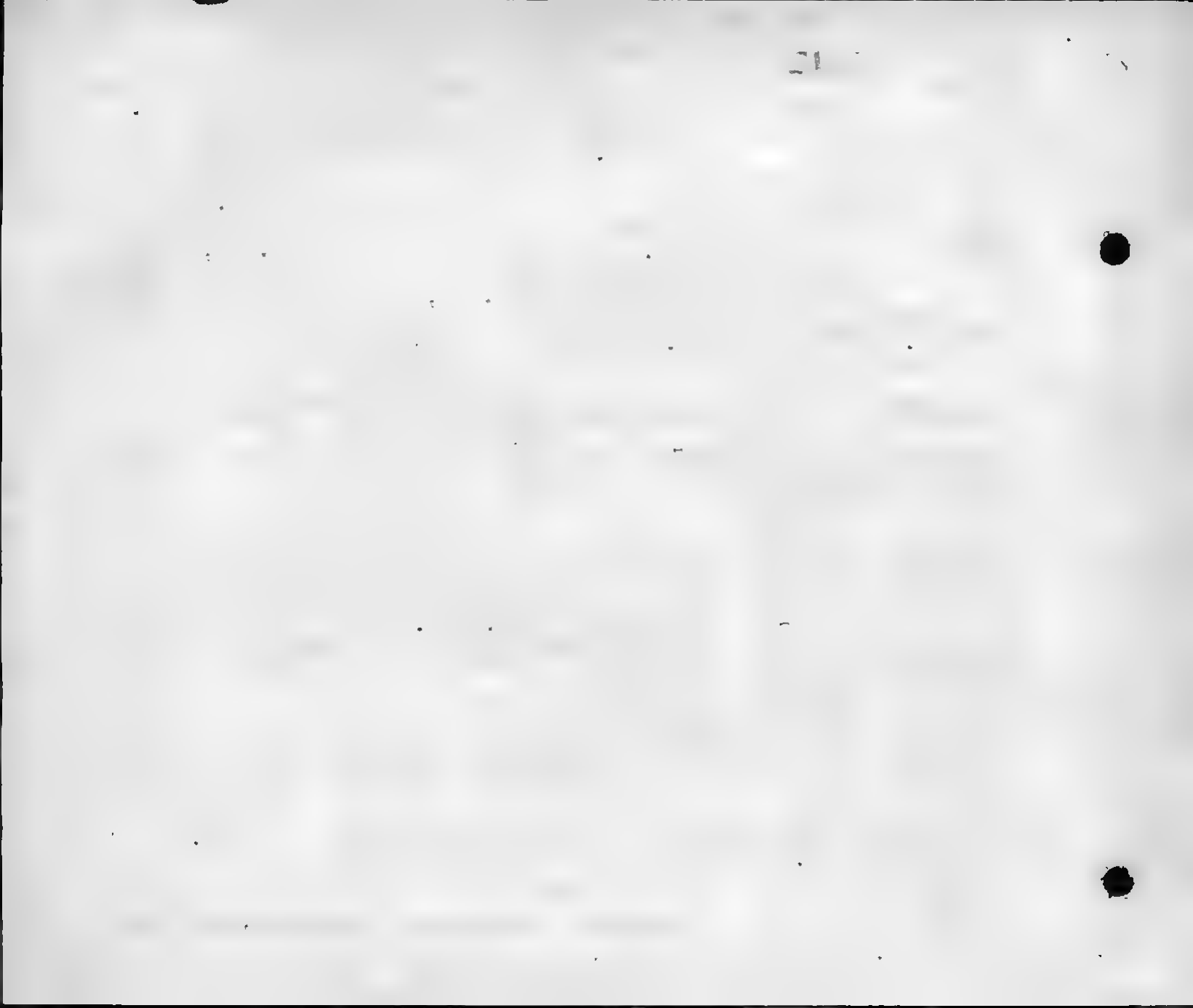
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3312 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resnor Nursing Home</b>				d. STREET ADDRESS <b>4750 Chevy Chase Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>E.</b> Last <b>Mason</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>26,</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Gov.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pub. Relations</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes—Unknown</b>		17. INFORMANT Address <b>Nursing Home Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b></b> (c), stating the underlying cause lost. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Hypertention - C V A several mos. ago.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

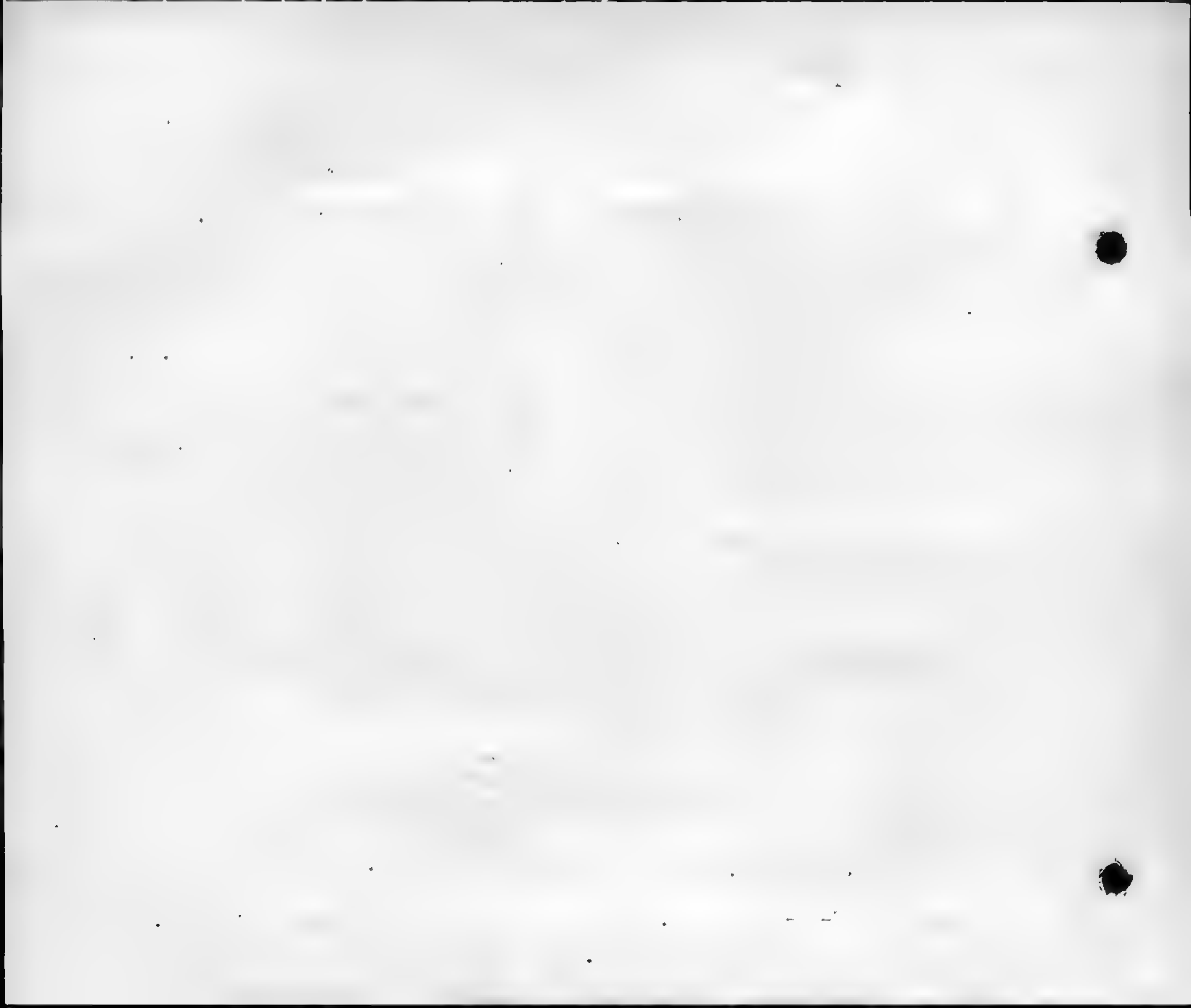
UNITED STATES DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3313

03301

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>13 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BILLY</b> M'ddle <b>BEN</b> Last <b>McFARLAND, JR.</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>19 61</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>BILLY BEN McFARLAND</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL FRANCES COLEMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity and Immaturity</b> <b>762.5</b> DUE TO <b>atelectasis of lungs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>3/26</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> 19 <b>61</b> , to <b>3/26</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/26</b> 19 <b>61</b> , and that death occurred at <b>4</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard A. Yates MD</b>		22b. DATE SIGNED <b>3/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Yates, M. D.</b>		22d. ADDRESS <b>Olney, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>		23d. LOCATION (City, town, or county) (State) <b>Laytonsville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>DATE APR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>L. S. H. H. H.</b>			

1.200 X 2

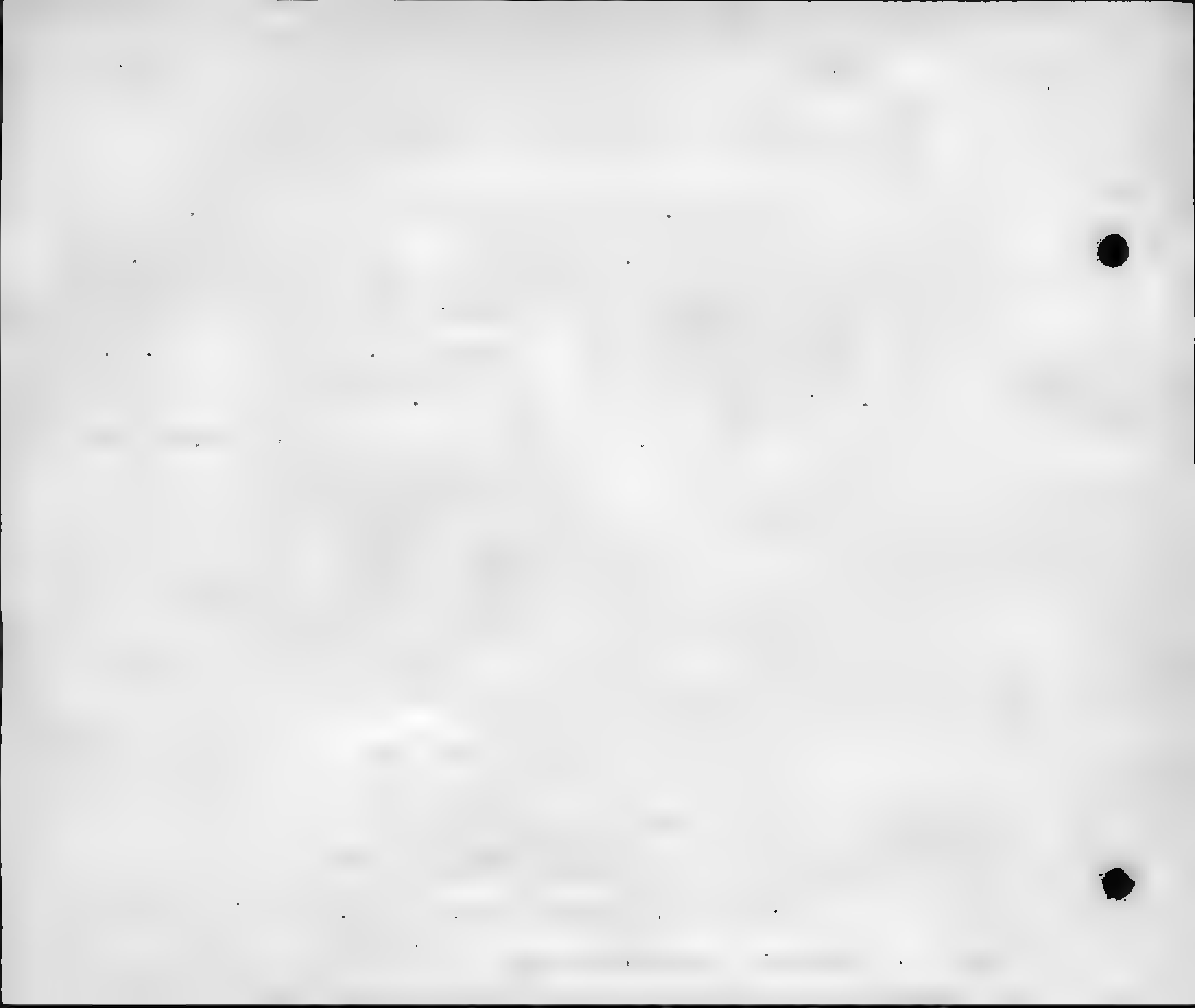


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
ISM 9/60

3314  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03302

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16605 Old Frederick Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>16605 Old Frederick Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First Middle Last <u>H. McFarlin</u>		4. DATE OF DEATH <u>March 8, 1961</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1882</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>New Castle, Delaware</u>		11. BIRTHPLACE (Country & State or foreign country) <u>U. S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Harry H. McFarlin</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Faulkner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>188-16-8439</u> 17. INFORMANT <u>Mrs. Otho Butcher-Friend-same above</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO <u>Carcinoma of intestine</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> DUE TO <u></u> causing the underlying cause test. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>about 1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 28, 1960</u> to <u>March 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1961</u> , and that death occurred <u>9:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr., M.D.</u>		22b. DATE SIGNED <u>March 9, 1961</u> 22d. ADDRESS <u>809 Veirs Mill Rd., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/11/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. George's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>St. George's Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>MAR 13 61</u> 25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

3315

03303

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELDON</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DELMONT NURSING HOME</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DERWOOD</u> d. STREET ADDRESS <u>FDAOR, MD.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALTA MCILWEE</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>5</u> Year <u>1961</u>	
<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-5-38</u> <b>9. AGE</b> (In years last birthday) <u>23</u> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MURSEY IND.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>ISSAC A. MCILWEE</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>WILLIS</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Edna, Md.</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - Bilateral</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic Heart Failure</u> (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>17 Days</u> <u>4 MO.</u> <u>10 years.</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JUNE 1960</u> <b>to</b> <u>FEB 5 1961</u> , that (I) (we) last saw the deceased alive on <u>FEB 5 1961</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>William Frank</u> M.D. <b>22b. DATE SIGNED</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>WILLIAM FRANK, M.D.</u> <b>22d. ADDRESS</b> <u>544 W. MONTGOMERY AVE ROCKVILLE, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>March 8, 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. James Lutheran</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Star Tannery, Virginia</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis L. Barber</u> ADDRESS <u>Laytonsville, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>MAR 8 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION





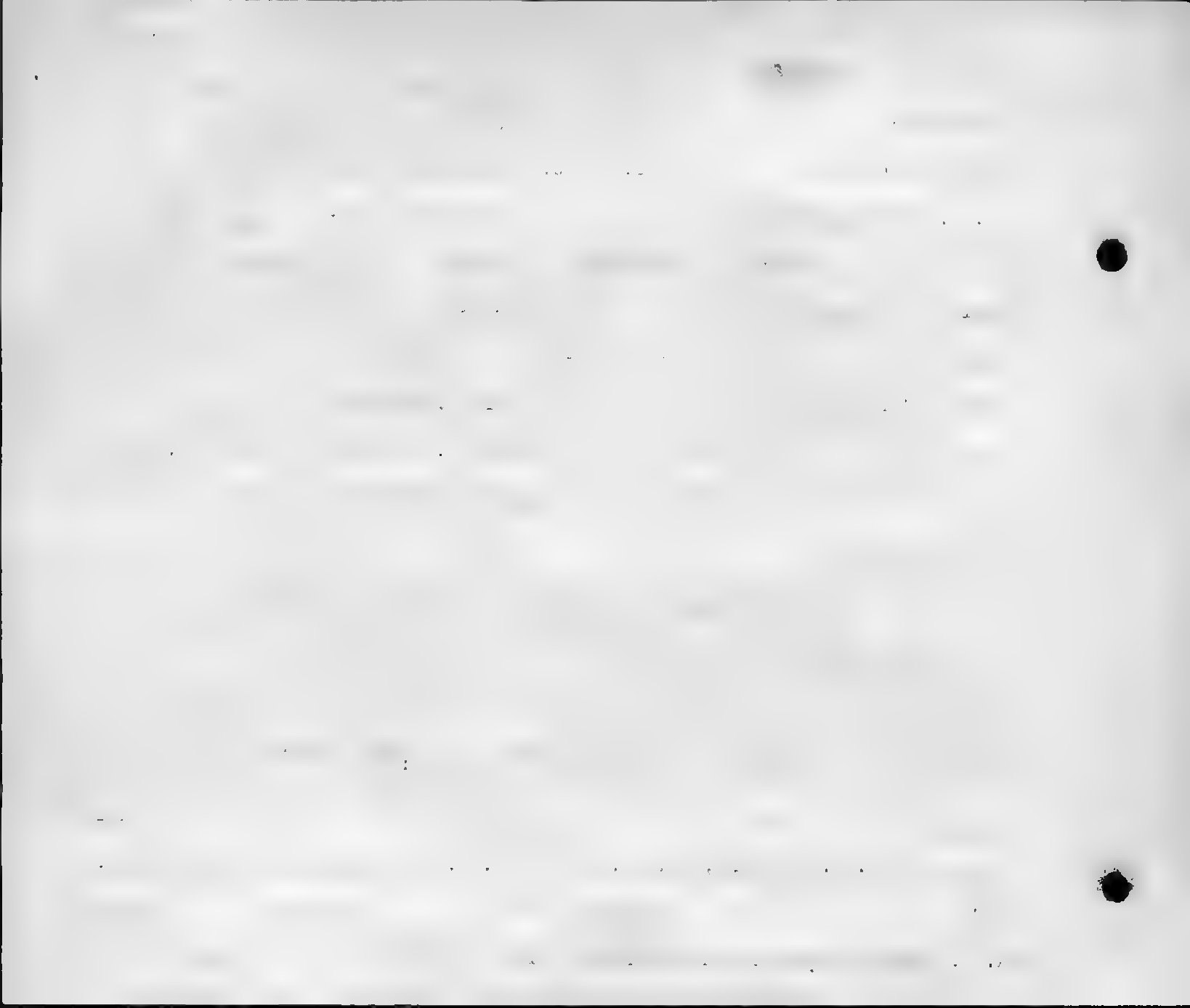
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**3316**

**18304**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN <u>MD</u> <u>1 yr. 7 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2409 Menckin Drive - Apt. 203</u> d. STREET ADDRESS <u>March 2, 1961</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Frances Callaway</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>Caucasian</u> h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>March 2, 1961</u> i. AGE (In years if UNDER 1 YEAR, last birthday) <u>61</u> yrs j. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u> k. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
<b>5. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>13. FATHER'S NAME</b> <u>Samuel Callaway</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>(H) BGEN Wm. N. McKelvy, USMC, Ret., same as #2</u>		<b>6. DATE OF BIRTH</b> <u>9-15-99</u> <b>7. AGE (In years if UNDER 1 YEAR, last birthday)</b> <u>61</u> yrs <b>8. BIRTHPLACE</b> (County & State, or foreign country) <u>Alabama</u> <b>9. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Breast, with metastasis</u> DUE TO (b) <u>170x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>12 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		<b>18. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>19. DATE</b> <u>3-2-61</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>2:20AM</u> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>21. I certify that</b> (X) (this hospital) attended the deceased from <u>July 8, 1959</u> to <u>March 2, 1961</u> that (X) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>2:20AM</u> , from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <u>G. B. Townsend</u> <b>22b. DATE</b> <u>3-2-61</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>G. B. TOWNSEND, LT, MC, USN</u> <b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3-6-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u> <b>23d. LOCATION (City, town or county)</b> <u>Arlington</u> <u>Virginia</u>		<b>24. VITAL DIRECTOR'S SIGNATURE</b> <u>R. A. Pumphrey</u> <b>25a. REC'D BY REGISTRAR</b> <u>Mar 6 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

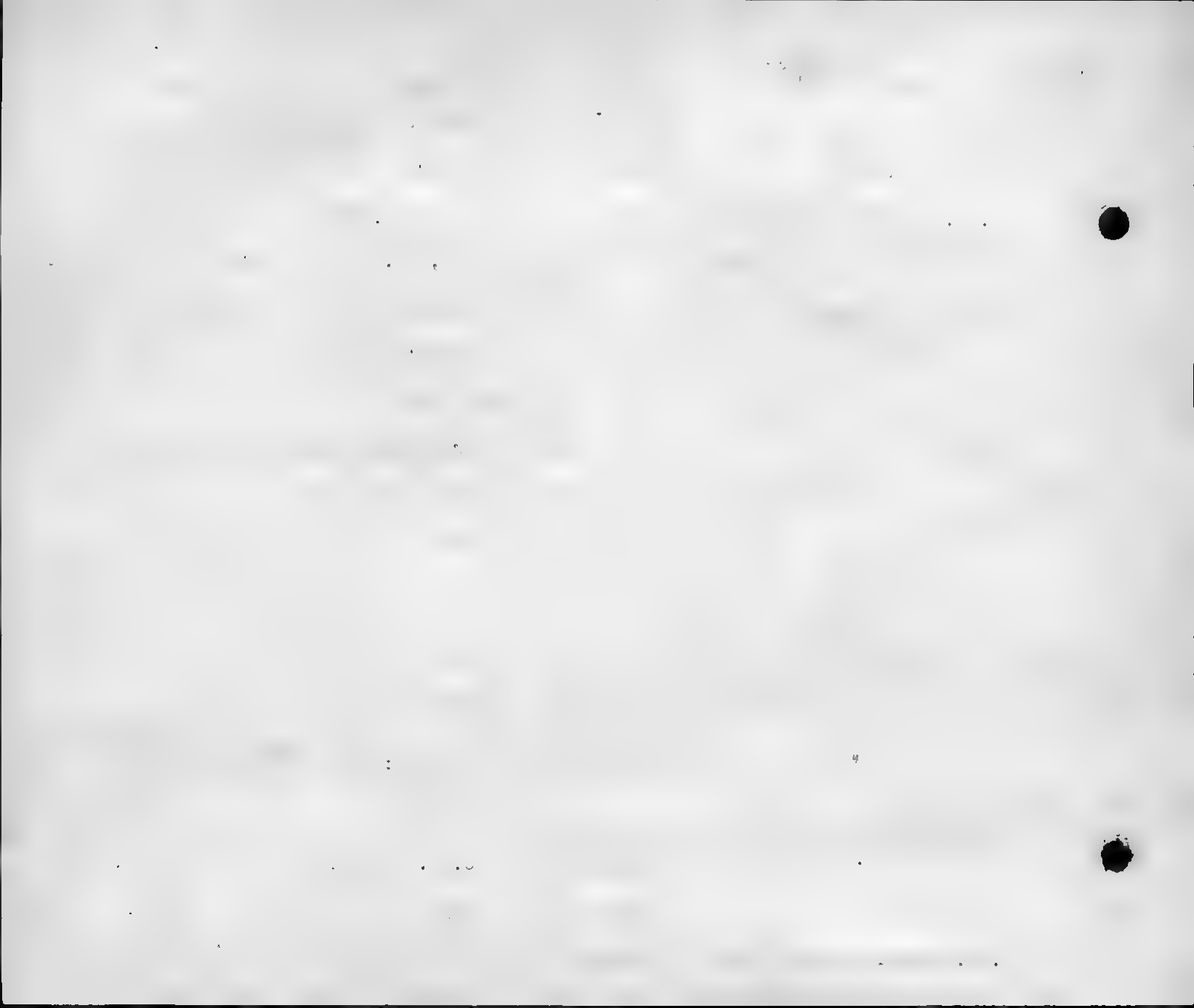


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3317 CERTIFICATE OF DEATH 03305

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Chester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>415 Evans Place</b> d. STREET ADDRESS <b>MC KNIGHT, JR.</b>		3. NAME OF DECEASED (Type or print) <b>Richardson</b> First Middle Last <b>Male</b> 5. SEX <b>Negro</b> 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>2-8-61</b> 19. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. <b>1 12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MC KNIGHT, JR.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b> 11. BIRTHPLACE (Country & State, or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Richardson MC KNIGHT</b> 14. MOTHER'S MAIDEN NAME <b>Mary THOMAS</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO <b>None</b> 17. INFORMANT <b>(F) Richardson McKnight, same as #2 above</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <b>MC</b> (this hospital) attended the deceased from <b>March 10 1961 11:10AM</b> to <b>March 20 1961</b> , that <b>MC</b> (we) last saw the deceased alive on <b>March 20 1961</b> , and that death occurred at <b>11:10AM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>C. W. BRAMLETT</b> 22c. PHYSICIAN'S NAME (Type) <b>C. W. BRAMLETT, LT, MC, USN</b> 22b. DATE SIGNED <b>3-21-61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment-3-22-61</b> 23b. DATE THEREOF <b>3-22-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Chester Pa.</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>B. F. Taylor</b> ADDRESS <b>WashDC</b> <b>B. F. Taylor Funeral Home, 909 6th St., NW,</b> 25a. REC'D BY REGISTRAR <b>DATE MAR 23 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

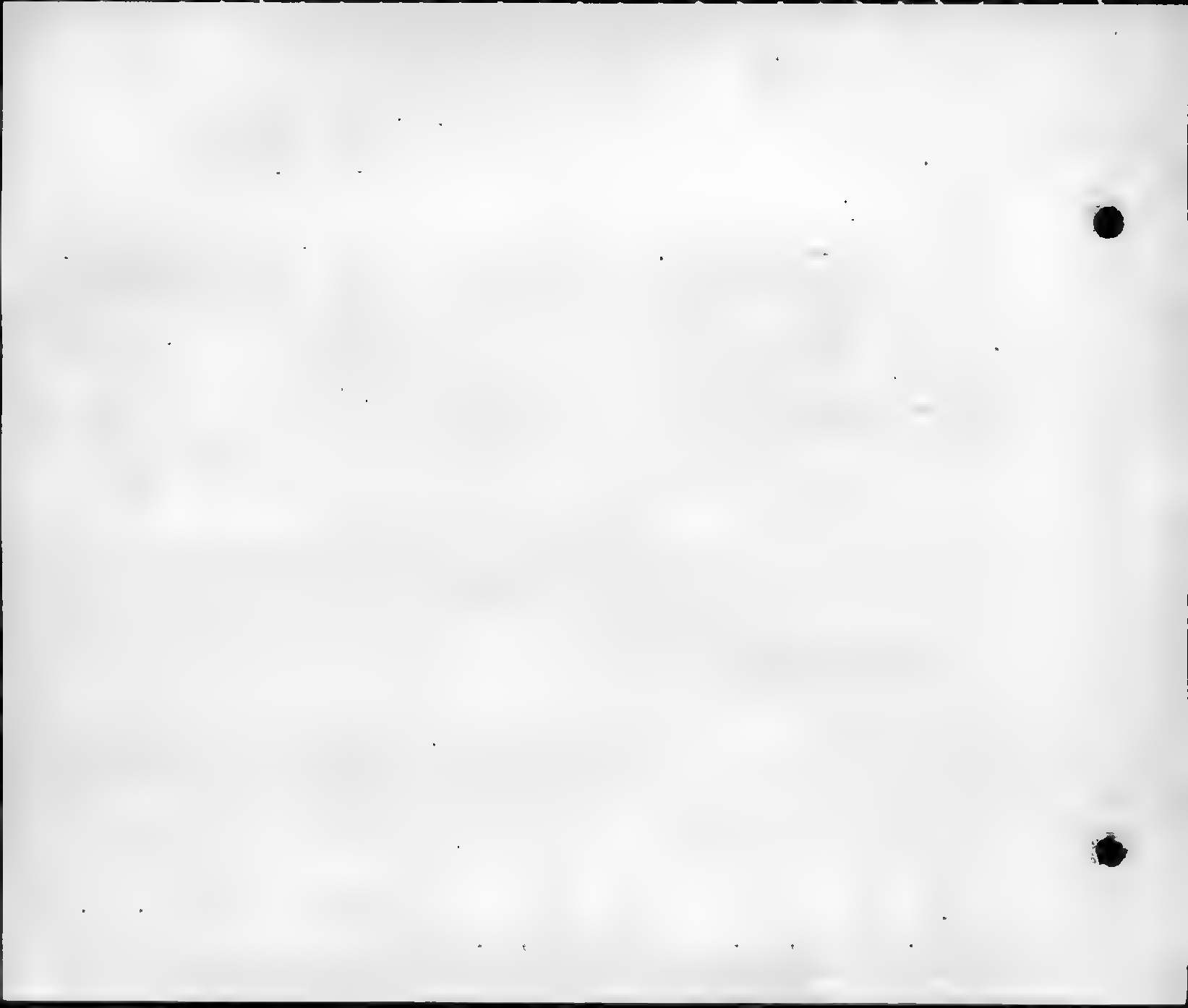
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3318

## CERTIFICATE OF DEATH

03306

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>3 Mo 11 da</u>				d. STREET ADDRESS <u>9305 Flower Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Martha E. — McSorley</u>				4. DATE OF DEATH <u>March 31 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs		10. FUND 1 YEAR		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section mgr. Dept. Store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper Ireland</u>			
11. BIRTHPLACE (State or foreign country) <u>Newspaper Ireland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Quinn</u>				14. MOTHER'S MAIDEN NAME <u>Anna Daly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>3</u>			
17. INFORMANT <u>Dorothy Quinn</u>				Address <u>9305 Flower Ave Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis &amp; occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <u>myocardial infarction</u> DUE TO (c) <u>Sen. int. sclerotic heart</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-20-60</u> to <u>31 Mar</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>25 Mar</u> 19 <u>61</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel B. Ziegler</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>				22d. ADDRESS <u>OLNEY, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>TRANS. &amp; BURIAL</u>		<u>4/1/61</u>		<u>FERNWOOD CEMETERY</u>		<u>FERNWOOD, DELAWARE CO., PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>				25a. REC'D BY REGISTRAR <u>DATA</u>			
ADDRESS <u>SILVER SPRING, MD.</u>				25b. REGISTRAR'S SIGNATURE <u>Carroll L. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

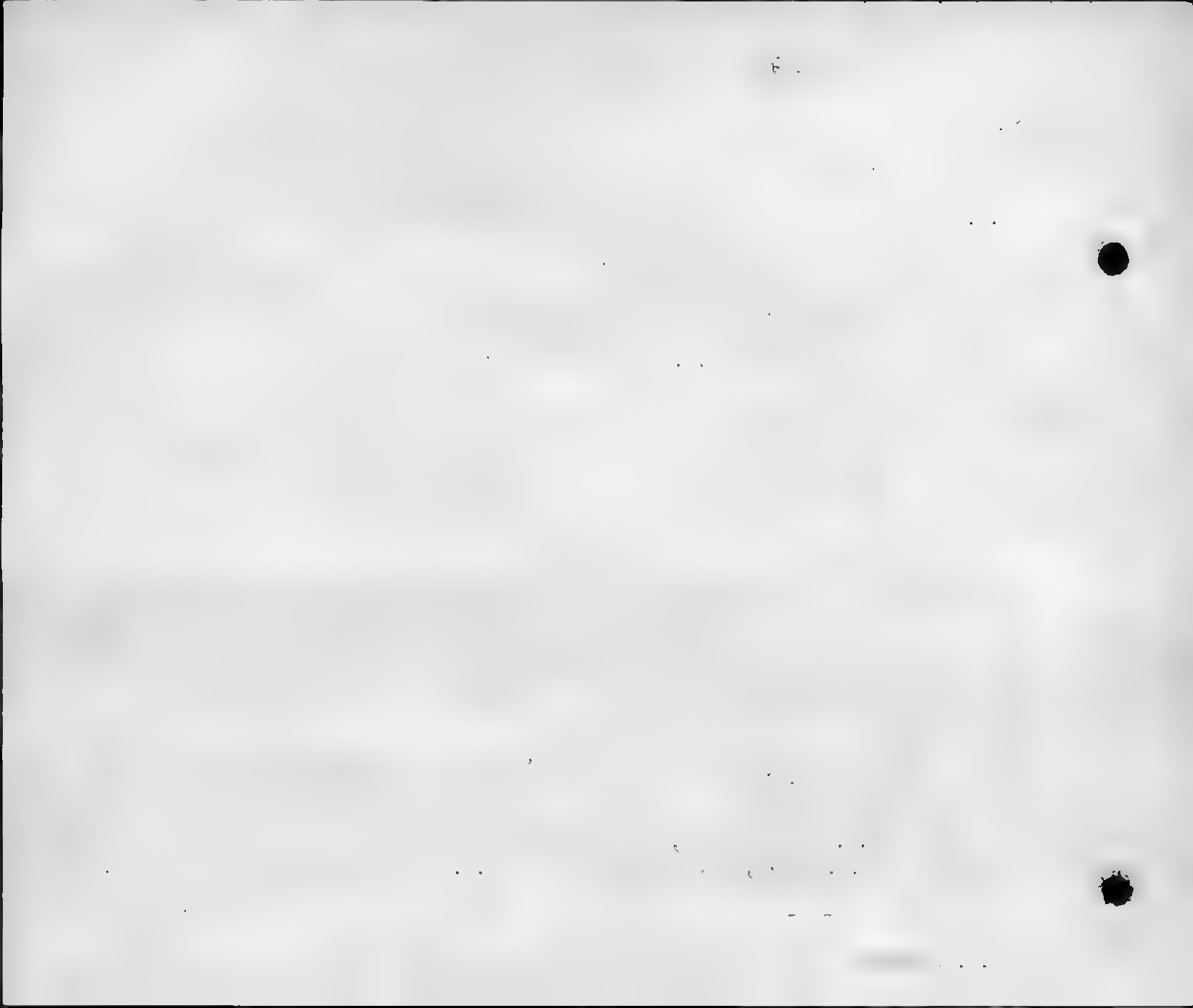
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3319

CERTIFICATE OF DEATH

03307

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>80 days</b>		2. USUAL RESIDENCE (Where deceased lived, if inst. on admission) e. STATE <b>Maryland</b>		f. COUNTY <b>Montgomery</b>		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		h. STREET ADDRESS <b>6404 Shadow Road</b>		i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>		3. NAME OF DECEASED (Type or print) <b>Milton Edward Miles</b>		4. DATE OF DEATH <b>March 25 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-6-00</b>		9. AGE (In years) IF UNDER 1 YEAR last birthday Months Days Hours M n. <b>60 yrs.</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Arizona</b>		12. MOTHER'S MAIDEN NAME <b>Mae Cook</b>		13. FATHER'S NAME <b>George A. Miles</b>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>yes 1918 to 1958</b>		15. SOCIAL SECURITY NO. <b>(W) Wilma Miles, same as # 2 above</b>		16. ADDRESS <b>177X</b>		17. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate wife metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO Cause test (c)		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Jan 4 1961</b> to <b>Mar 25 1961</b> , that (X) (we) last saw the deceased alive on <b>March 25 1961</b> , and that death occurred at <b>850PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>S.T. Knappenberger</b>		22b. DATE SIGNED <b>3-25-61</b>		22c. PHYSICIAN'S NAME (Type) <b>S.T. KNAPPENBERGER, LT, MC, USNR</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS <b>Bethesda, Maryland</b>		22g. REC'D BY REGISTRAR <b>DAMAR 28 '61</b>		22h. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		23e. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>		23f. ADDRESS <b>7657 Wisconsin Avenue</b>		23g. DATE <b>MAR 28 '61</b>		23h. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>		23i. ADDRESS <b>Bethesda, Maryland</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

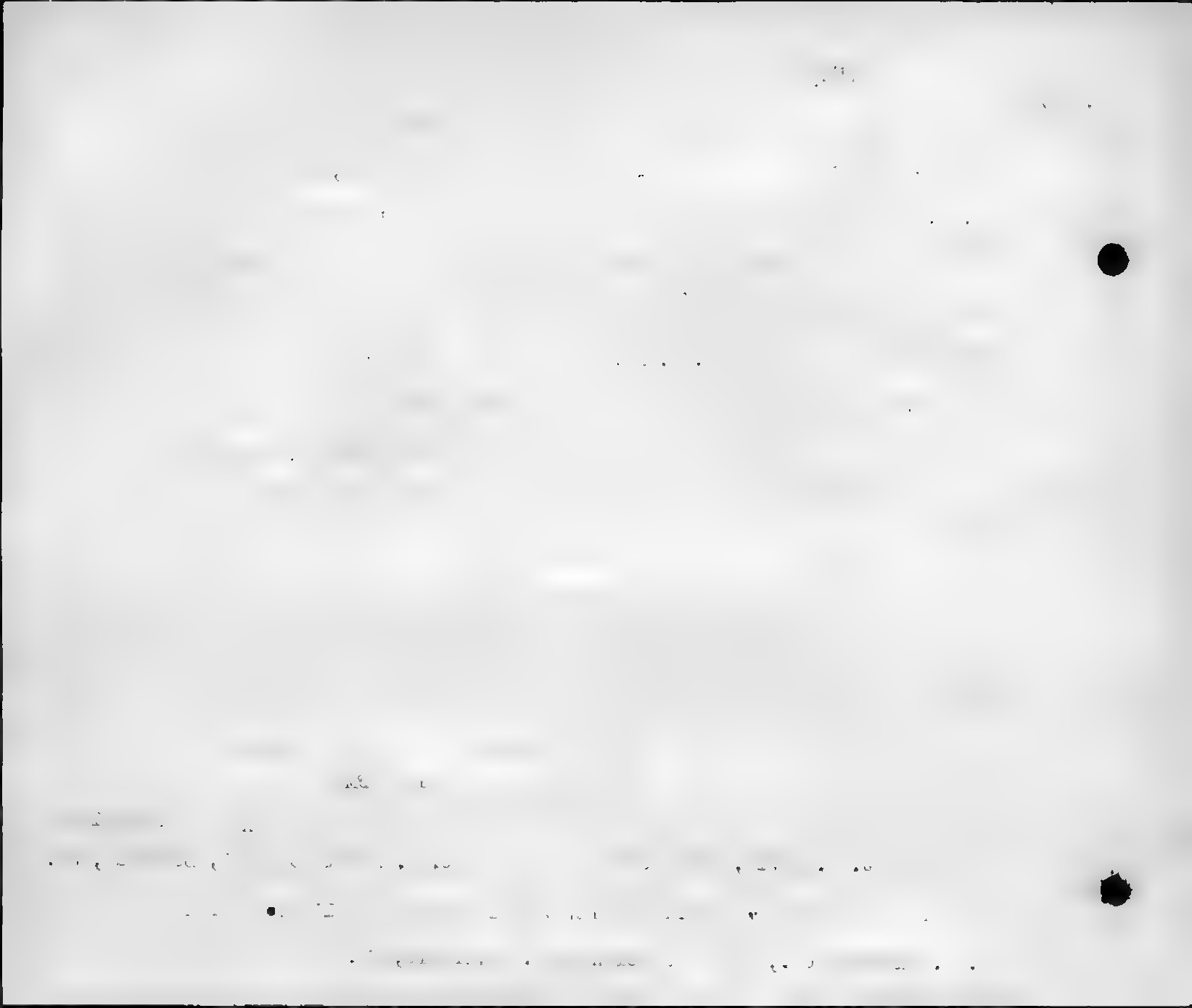
## CERTIFICATE OF DEATH

3320

03308

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>13 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville, Md.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> d. STREET ADDRESS <u>5002 70'th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nicholas Leslie Molloy</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>March 25 1961</u> Month Day Year			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-12-02</u>	
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Enlisted</u>				<b>11. BIRTHPLACE</b> County & State, or foreign country <u>New York</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John F. Molloy</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Horton</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u>				<b>16. SOCIAL SECURITY NO.</b> <u>(W) Margaret Olive Molloy</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>151X</u> (a), stating the underlying cause last, (c) DUE TO							
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 12</u> 19 <u>61</u> to <u>March 25</u> 19 <u>61</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 25</u> 19 <u>61</u> , and that death occurred <u>1961</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>John W. Davis, LT MC USN</u>				<b>22b. DATE SIGNED</b> <u>26 March 1961</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>J. W. DAVIS, LT MC USN</u>				<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 29, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery Arlington Virginia</u>		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers Co., 5801 Cleveland Ave. Riverdale, Md.</u>				<b>25. REC'D BY REGISTRAR</b> <u>MAR 28 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03303

3321

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY (in hrs.) <u>36 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1520 Potomac Ave., S.E.</u> e. DATE OF DEATH <u>March 18 1961</u> f. AGE (in years, if under 1 year, last birthday) <u>1</u> yrs. <u>1</u> month <u>1</u> day <u>19</u> hr. <u>61</u> min. g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Patricia MOORE</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>3-17-61</u> 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>William Ferrell MOORE</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine BERNSTINE</u>					

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>(F) Wm. F. Moore, same as #2 above</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO <u>Prematurity (1 lb. 8 oz.)</u> Conditions, if any, which gave rise to immediate cause (b) <u>36 hrs.</u> (c), stating the underlying cause last. <u>36 hrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) <u>None</u>
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<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
<b>20c. TIME OF INJURY</b> Hour <u>7:40 PM</u> Month <u>March</u> Day <u>17</u> Year <u>1961</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, Bethesda, Md.</u>	<b>20f. (City or town)</b> (County) (State) <u>Washington, D. C.</u>

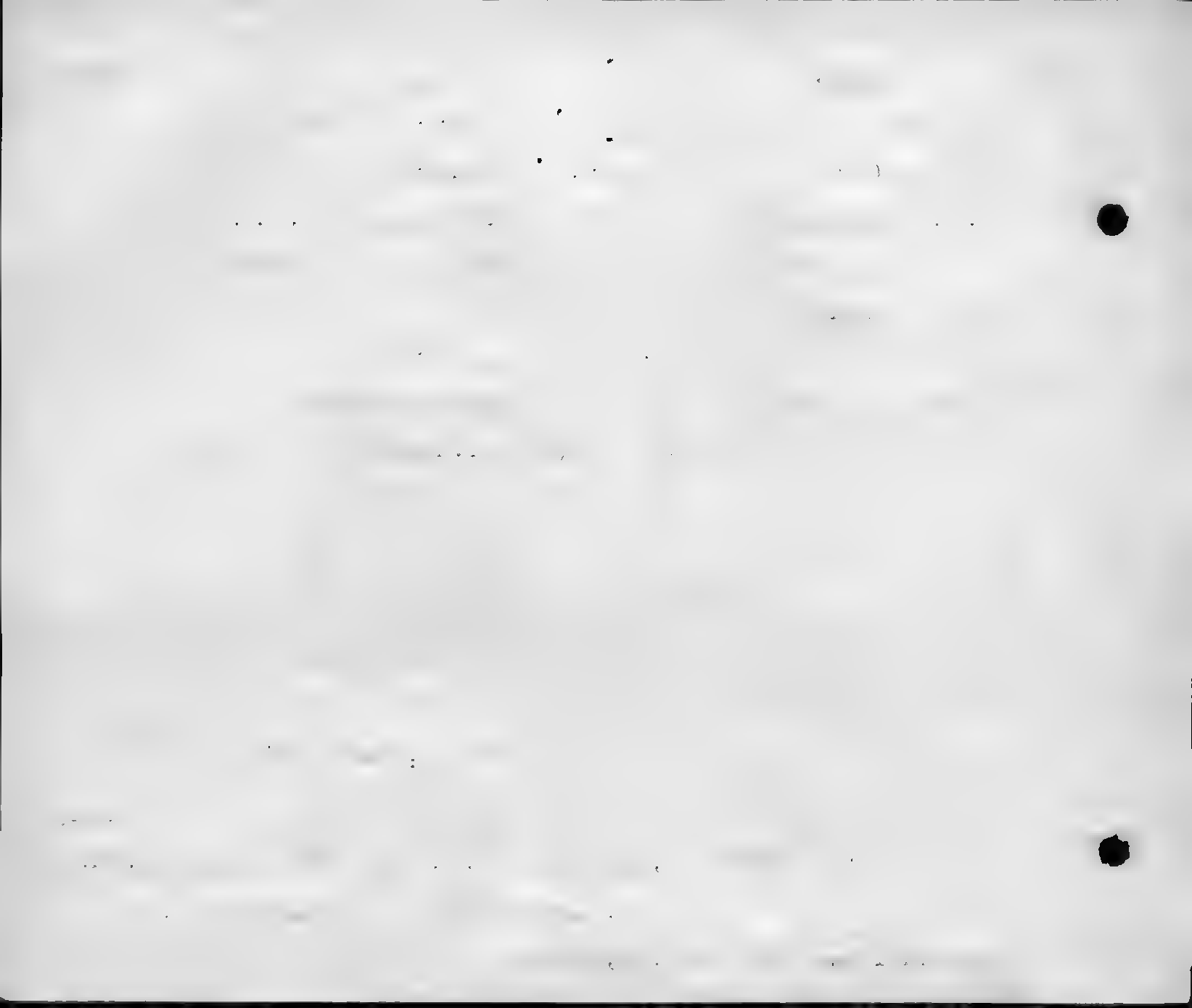
<b>21. I certify that</b> (X) (this hospital) attended the deceased from <u>March 17 1961</u> to <u>March 18 1961</u> that (X) (we) last saw the deceased alive on <u>March 18 1961</u> , and that death occurred at <u>7:40 PM</u> from the causes and on the date stated above.	
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<b>22a. SIGNATURE</b> <u>Fred W. Grello</u> M.D.	<b>22b. DATE SIGNED</b> <u>3-19-61</u>
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Fred W. GRELLO, LT, MC, USN</u>	

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>3-21-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>	<b>23d. LOCATION (City, town or county)</b> (State) <u>Washington, D. C.</u>
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<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Pope Funeral Home, 414 15th St., SE, WashDC</u>	<b>25a. REC'D BY REGISTRAR</b> <u>MAR 21 '61</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Hines</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

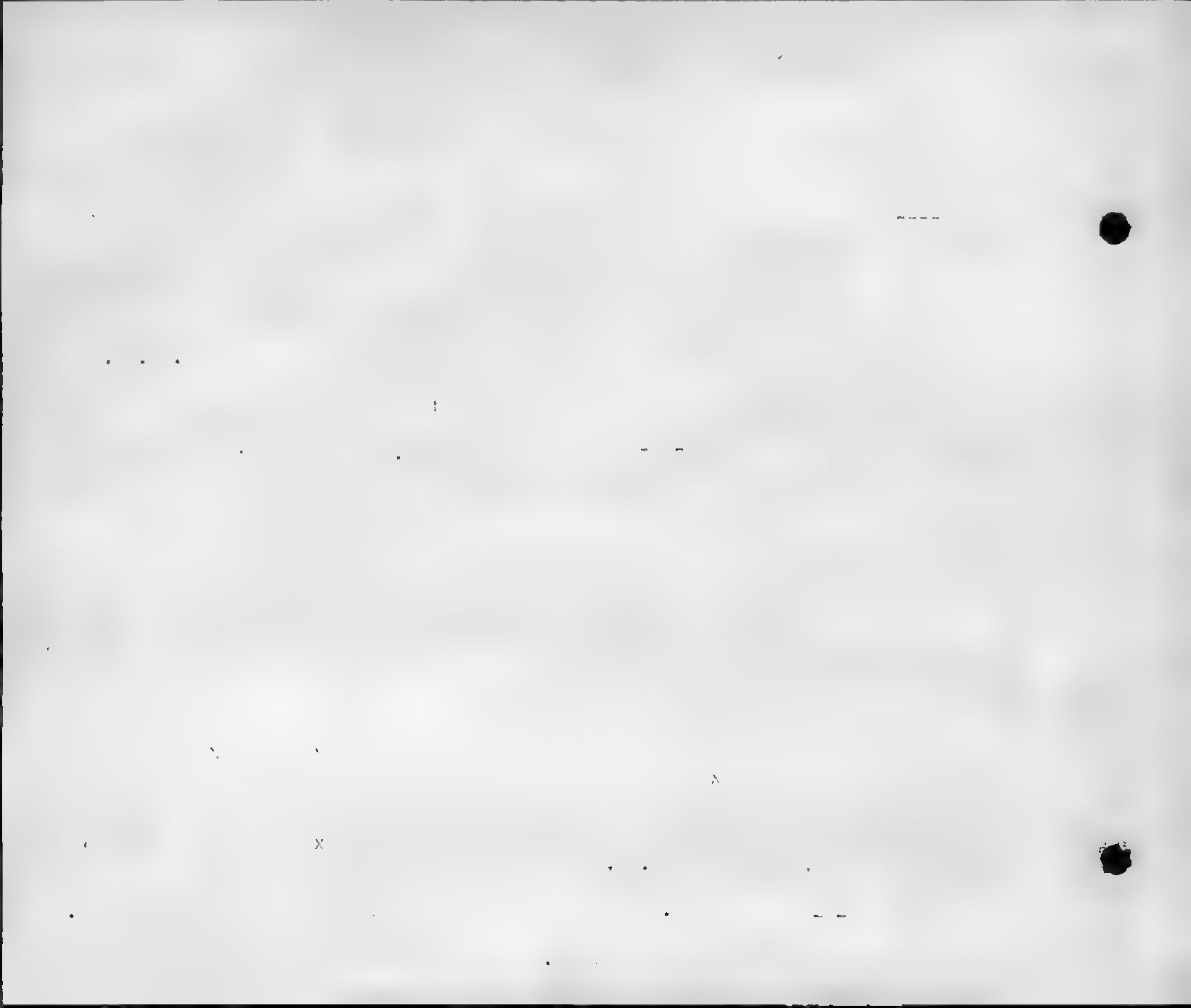
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AJSME  
5M 7/59

MEDICAL CERTIFICATION

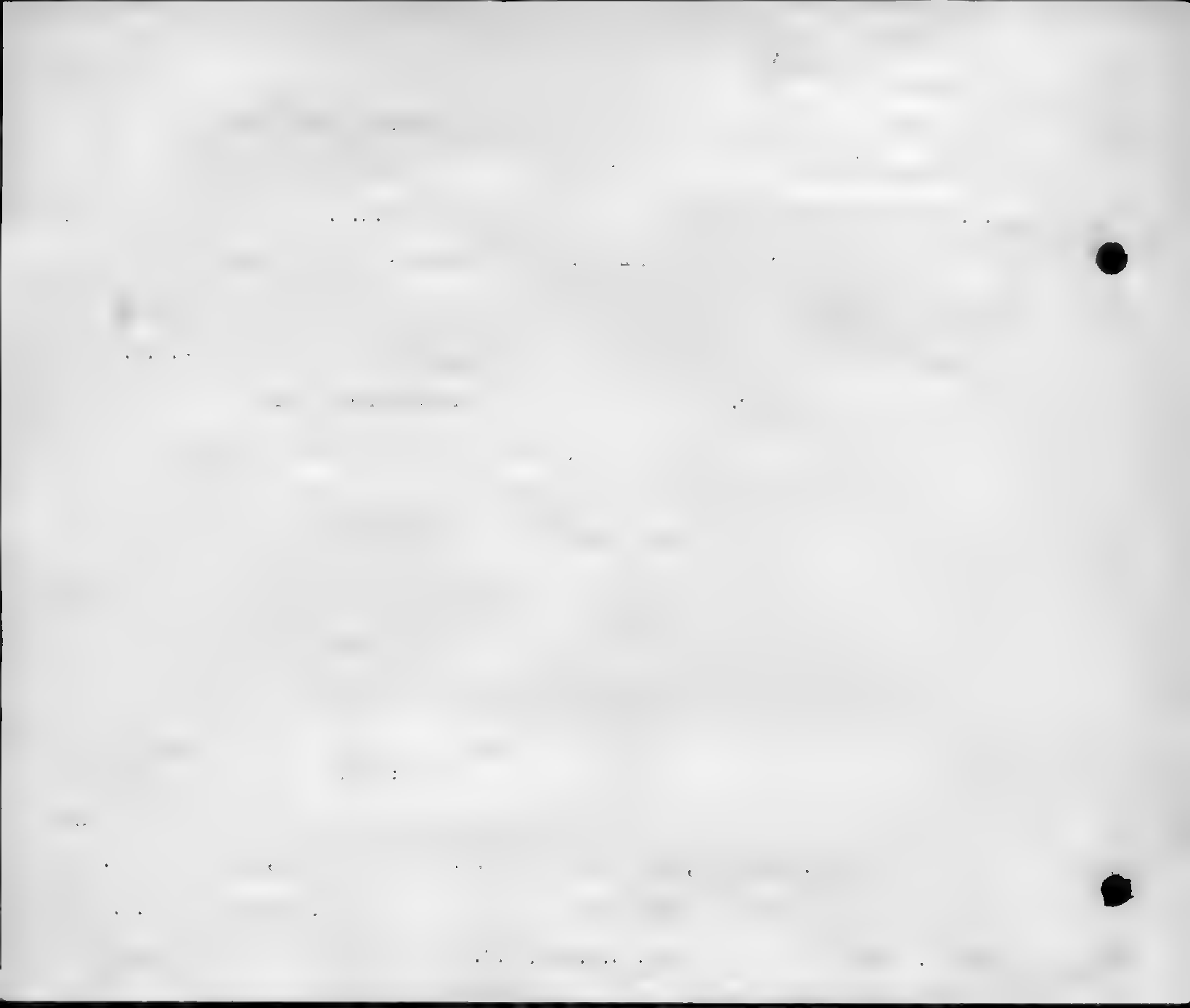
MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03310									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ETCHISON</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ETCHISON</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Northbury R-2</b>					d. STREET ADDRESS <b>1 Northbury R-2</b>				
3. NAME OF DECEASED (Type or print) <b>RUSSELL GORMAN MOORE</b>					4. DATE OF DEATH <b>MARCH 6 1961</b>				
5. SEX <b>MALE</b>					6. COLOR OR RACE <b>WHITE</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <b>12/31/1896</b>				
9. AGE (In years last birthday) <b>64 yrs.</b>					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>					11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				
10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>LUTHER JAMES MOORE</b>					14. MOTHER'S MAIDEN NAME <b>LYDIA EDNA WARFIELD</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>217-36-6466</b>				
17. INFORMANT <b>FAMILY Mrs. Russell Moore</b>					Address <b>Same as 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>CORONARY OCCLUSION</b>									
DUE TO (b) _____									
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <b>3/6/61</b>									
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.									
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART, M. D.</b>									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>3-9-61</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor</b>									
22d. LOCATION (City, town, or country) (State) <b>Etchison Montgomery Md.</b>									
23. FUNERAL DIRECTOR <b>Francis H. Barber</b> <b>Laytonville, Md.</b>									
24a. REC'D BY REGISTRAR <b>MAR 9 '61</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL STATISTICS: After this certificate has been signed by the attending physician and completed by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3323  
CERTIFICATE OF DEATH  
03311

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY in lb <b>11 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>403 50th. ST. N.E. Apt 31</b> e. IS RESIDENCE ON A FARM? <b>NO</b>	
3. NAME OF DECEASED (Type or print) <b>Fred Mandell</b>		4. DATE OF DEATH <b>MORRIS Jr. March 3 19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negroid</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-4-60</b>	
9. AGE (in years last birthday) <b>3 yrs.</b>		10. IF UNDER 1 YEAR <b>3 Months 29 Days</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Fred Mandell MORRIS Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Aloneze DYKES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(F) Fred M. Morris, same as #2 above</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>meningitis</b> DUE TO (b) <b>porencephalic cysts</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS 3 MOS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>12-14-1960</b> to <b>3-3-1961</b> , that (X) (we) last saw the deceased alive on <b>3-3-1961</b> , and that death occurred at <b>10:28 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. Rack, MD</b>		22b. DATE SIGNED <b>3-3-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. RACK, LT, MC, USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION (City, town or county) (State) <b>S.E. WASHINGTON D.C.</b>	
24. REGISTRAR'S SIGNATURE <b>John T. STEWART</b>		25a. REC'D BY REGISTRAR <b>MAR 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			





3324

## CERTIFICATE OF DEATH

Reg. Dist. No. 03312

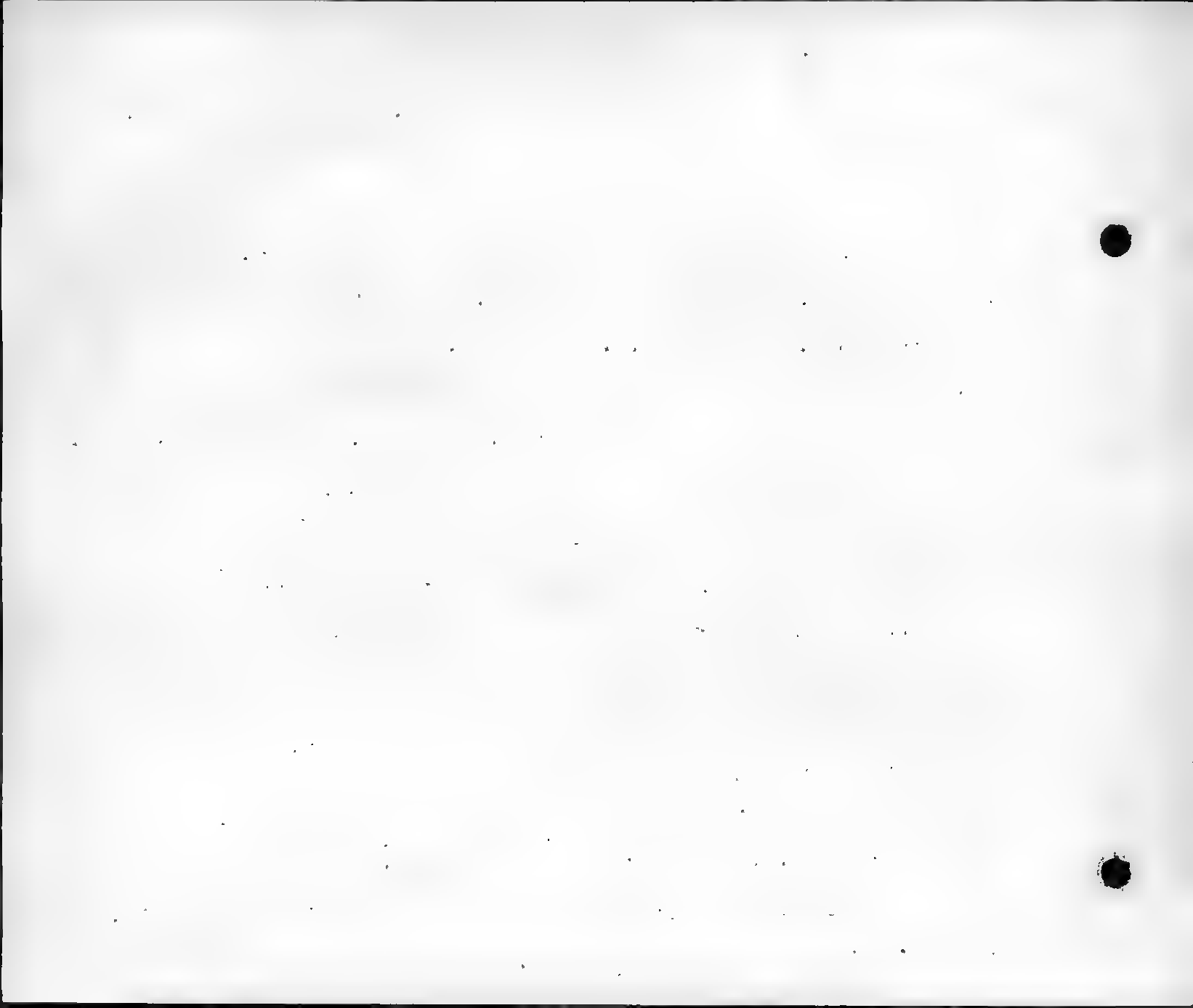
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Mont.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Trail Mullican</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>March 10 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1870</b>
9. AGE (In years last birthday) yrs <b>91</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rail road emp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Mullican</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Trail</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT Address <b>Mrs. Bertie M. Hagan -Derwood, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>COLON BOY + THROM BOSIS</b> 250X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last (b) <b>DIABETES MELLITUS</b> DUE TO (c) <b>HYPERTENSIVE HTEROCULOTIC HEMIT DISEASE 20YRS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <b>6L1D OSTEO MYELITIS OF LEFT LEG</b>			INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b> <b>2 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>APRIL 24, 1956</b> to <b>MARCH 10 1961</b> , that I last saw the deceased alive on <b>FEBRUARY 29 1961</b> , and that death occurred at <b>2:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>310 West Montgomery Ave. 3/10/61</b>	
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>		<b>Rockville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-13-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		24a. REC'D BY REGISTRAR <b>MAR 14 '61</b>	
ADDRESS <b>Laytonville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the spaces 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon paper. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

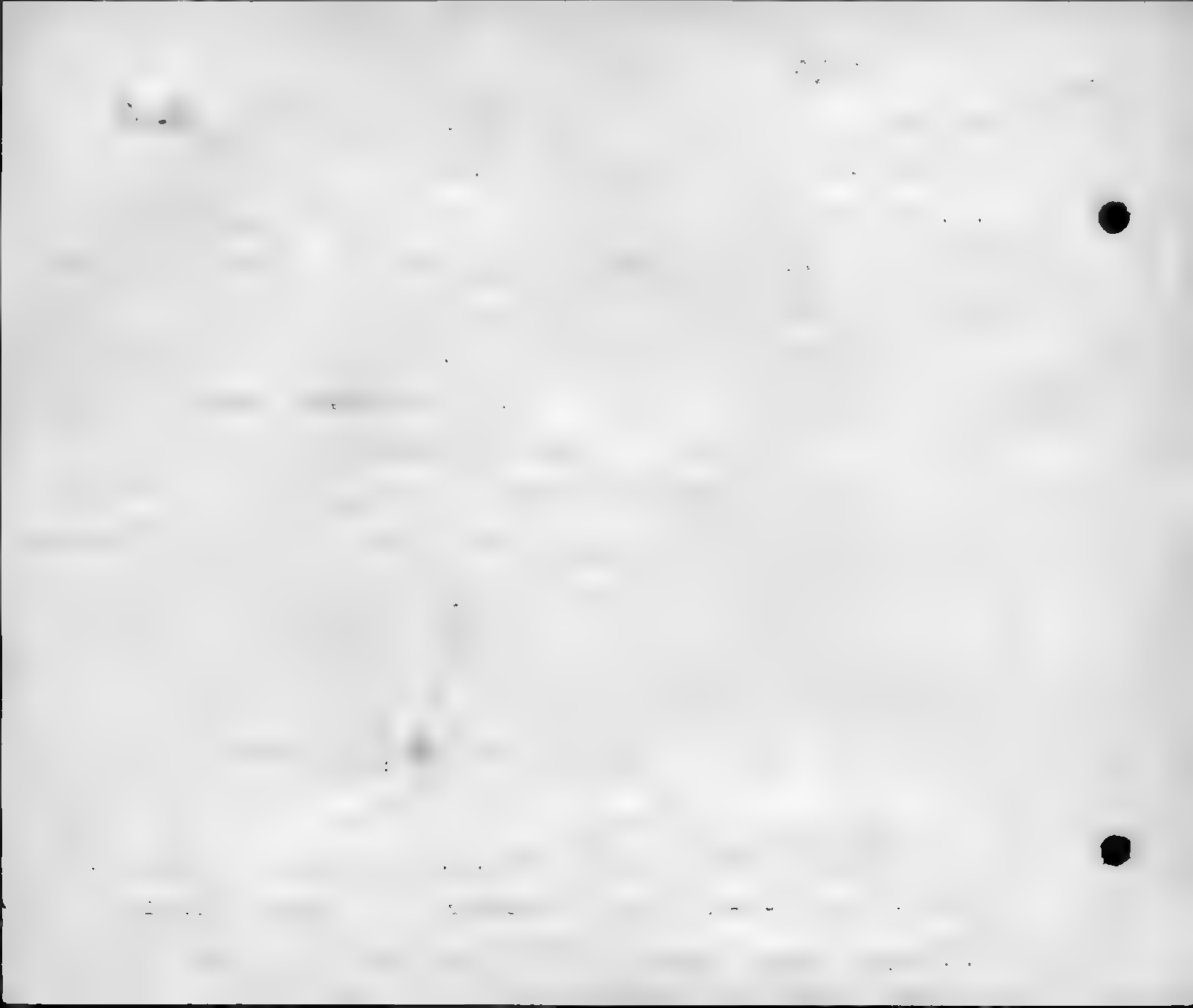
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3325

03313

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY A.A.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft. Meade	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 1235 C 25th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) Judith Ann Nichols		<b>4. DATE OF DEATH</b> March 24 19 61		9. AGE (in years if UNDER 1 YEAR, if UNDER 24 HRS., last birthday) 2-15-61	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) None		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> None		<b>11. BIRTHPLACE</b> (County & State or foreign country) Maryland A.A.	
<b>13. FATHER'S NAME</b> Ralph E. NICHOLS		<b>14. MOTHER'S MAIDEN NAME</b> Jewel Dean DOWLING DOWNING		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) NO		<b>16. SOCIAL SECURITY NO</b> None		<b>17. INFORMANT</b> Hospital Records	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		Malnutrition Fibrosystic disease		INTERVAL BETWEEN ONSET AND DEATH 7 hrs. Congenital	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 19	
<b>20f. (City or town)</b> Pontiac		<b>(County)</b> Michigan		<b>(State)</b>	
<b>21. I certify that</b> (this hospital) attended the deceased from March 21, 1961 to March 24, 1961 that (I) (we) last saw the deceased alive on March 24, 1961, and that death occurred at 11:25 AM, from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> Lawrence G. Throne		<b>22b. DATE SIGNED</b> 3-24-61		<b>22c. PHYSICIAN'S NAME</b> (Type) Lawrence G. THRONE, LT, MC, USN	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial-Shipment 3-25-61		<b>23b. DATE THEREOF</b> 3-25-61		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Perry Mount Cemetery	
<b>23d. LOCATION</b> (City, town or county) Pontiac		<b>(State)</b> Michigan		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> R.A. Pumphrey	
<b>24. ADDRESS</b> Bethesda, Md.		<b>25a. REC'D BY REGISTRAR</b> DATE MAR 28 '61		<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Kraus	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

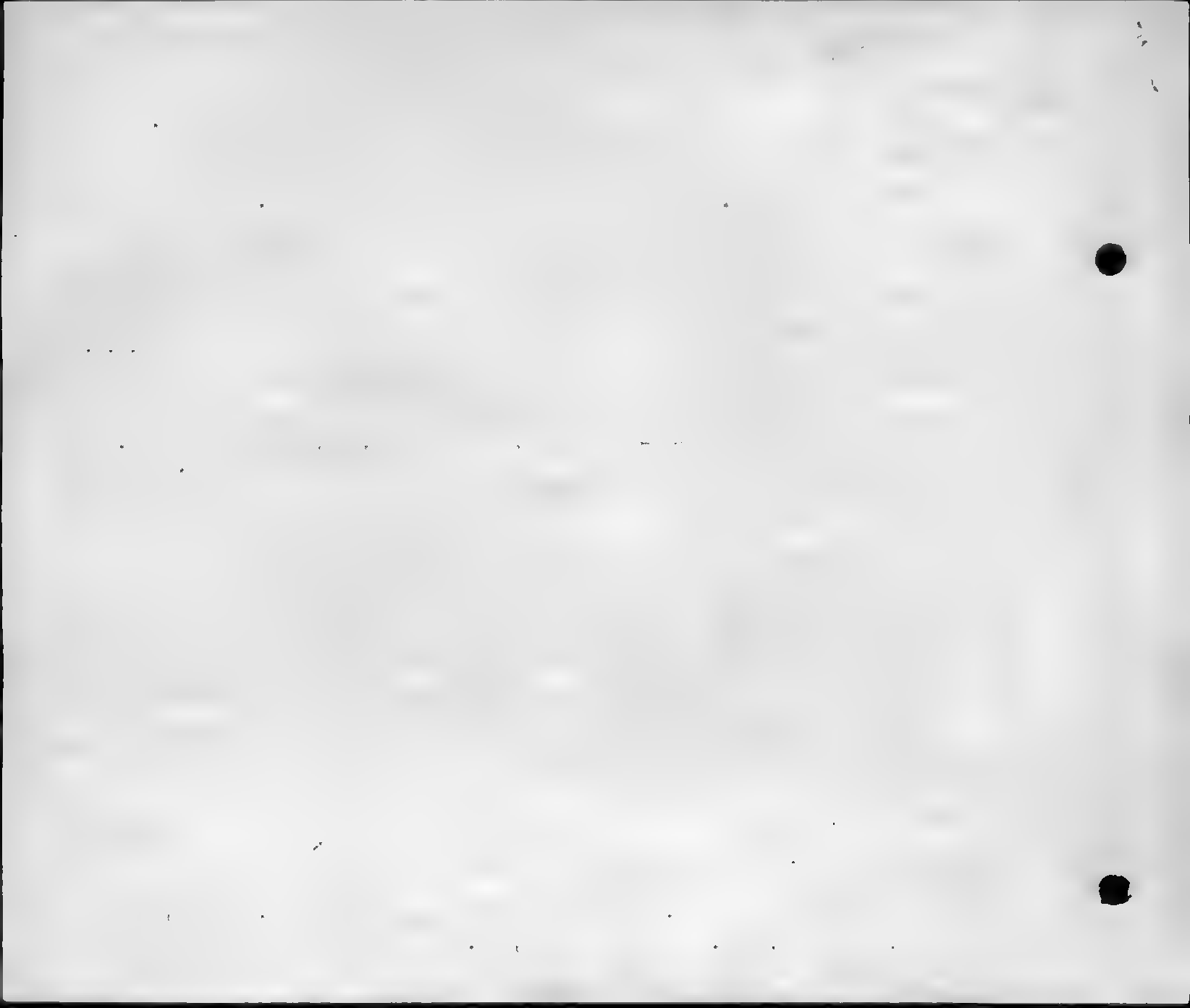
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03314

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN b <b>12 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10412 Edgewood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Myrtle Whitney Niles</b>		4. DATE OF DEATH <b>3/21/61</b>	
5. SEX <b>fe male</b> 6. COLOR OR RACE <b>w hite</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/23/1878</b> 9. AGE (In years) IF UNDER 1 YEAR <b>82</b> Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANCIS WHITNEY</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA NETHERcutt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>261-14-5955</b>	
17. INFORMANT <b>Mrs. Peggy Niles</b>		Address <b>10,412 Edgewood Ave. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>History of hypertension and CVA about 3 years ago</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/24/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR <b>WARNER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>MAR 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the medical examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the medical examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the medical examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1  
FOR STATE  
HEALTH DEPT.

(M)

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03315											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 hrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11119 Brandin Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bernard Celemore Noyes</u>				4. DATE OF DEATH <u>March 11 1961</u>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>				6. COLOR OR RACE <u>W</u>				7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>			
8. DATE OF BIRTH <u>February 7, 1910</u>				9. AGE (In years last birthday) <u>51</u> yrs.				10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Albert Lagginess</u>				14. MOTHER'S MAIDEN NAME <u>Viola Hursey</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Wife Esther Noyes</u> Address <u>Some address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin disease</u> DUE TO (b) <u>201X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>8 yrs</u> DUE TO (c) <u>8 yrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
21. ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-11-61</u>			
21. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-15-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>				23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 17 '61</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

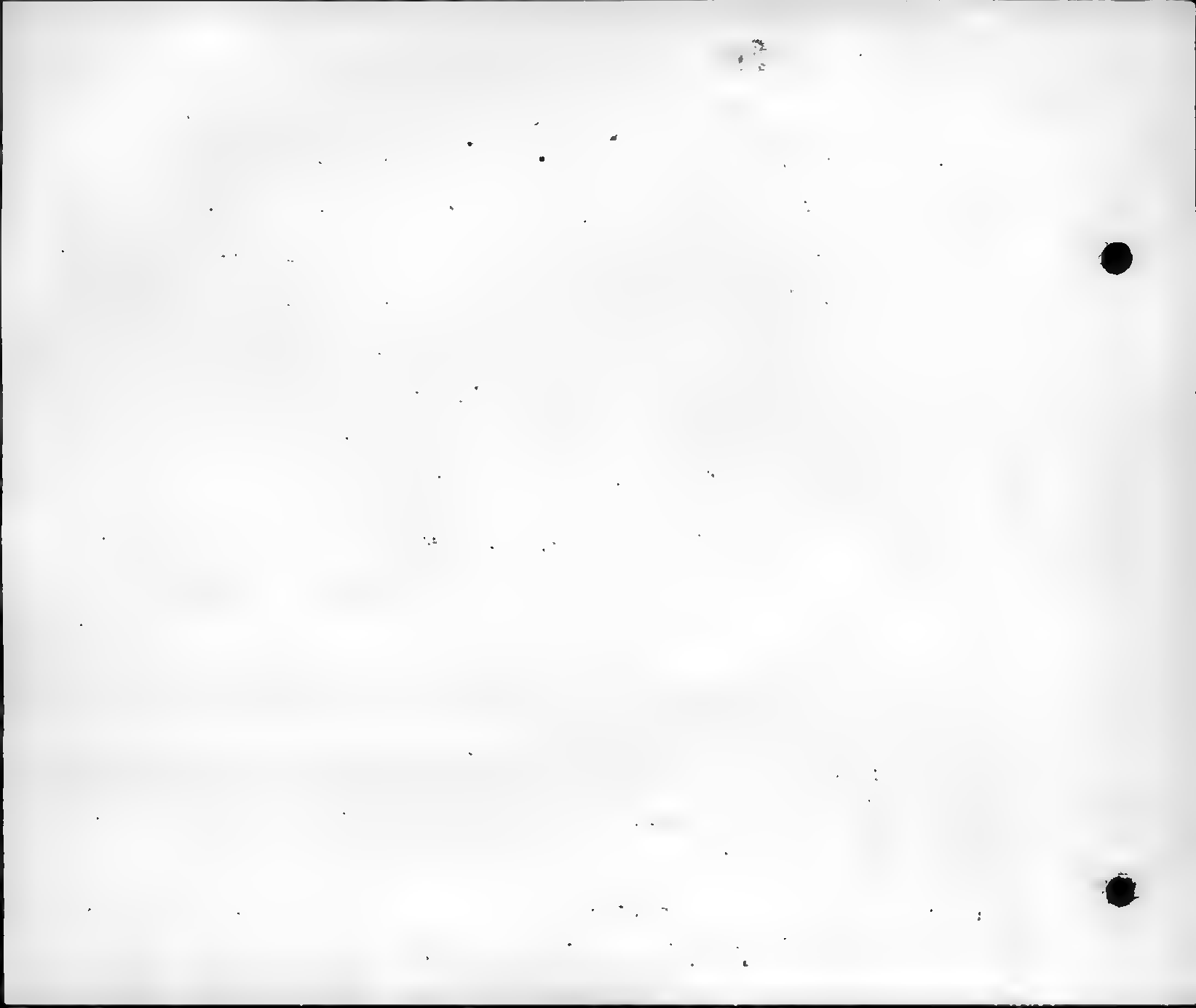
CERTIFICATE OF DEATH

Reg. Dist. No.

03316

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>1. ROCKVILLE</u> d. STREET ADDRESS <u>111418 Schuyler Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>A" OAKES</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27, 1961</u>
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HOWARD LEROY OAKES</u>		14. MOTHER'S MAIDEN NAME <u>NATALIE ESTELLE SPAIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>FATHER</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature labor</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute hydramnios</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/27</u> , 19 <u>61</u> , to <u>3/27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. E. Renshaw</u>		ADDRESS (Street, city or town, state) <u>1150 CONNECTICUT AVE. N.W. WASH DC</u>	
PHYSICIAN'S NAME (Type) <u>Josephine E. Renshaw MD</u>		DATE <u>1150 CONNECTICUT AVE N.W. WASH DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3-28-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>BETHESDA, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia Carter, (purs.)</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 3 '61</u>	
ADDRESS <u>Suburban Hospital, Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Pina</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
3329 CERTIFICATE OF DEATH									
Reg. Dist. No. 03317									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>45 minutes</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>11418 Schuykill Rd 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>"B" OAKES</u>					4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1961</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 27 1961</u>		9. AGE (In years last birthday) <u>—</u> yrs <u>—</u> months <u>—</u> days <u>—</u> hours <u>—</u> min <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Le Roy Oakes</u>					14. MOTHER'S MAIDEN NAME <u>Natalie Estelle Spaid</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO <u>—</u>		INFORMANT <u>Father</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature labor</u> <u>773.5</u> DUE TO <u>acute hydrops</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>3/27</u> 19 <u>61</u> , to <u>3/27</u> 19 <u>61</u> , that I last saw the deceased alive on <u>3/27</u> 19 <u>61</u> , and that death occurred at <u>7:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 CONNECTICUT AVE NW WASH DC</u> DATE SIGNED <u>—</u> ACTUAL SIGNATURE <u>J. Renshaw</u> PHYSICIAN'S NAME (Type) <u>JOSEPHINE E RENSHAW M.D.</u> <u>1150 CONNECTICUT AVE NW WASH DC</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-28-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Imilia Carter</u> ADDRESS <u>Suburban Hospital Bethesda, Md.</u>					24a. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3330

03318

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11901 ANDREW ST.</u>				d. STREET ADDRESS <u>11901 ANDREW ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM T. OGLE</u>				4. DATE OF DEATH Month Day Year <u>March 19 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/23/1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM T. OGLE SR.</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET DUNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. MARGARET M. OGLE</u>		Address <u>11901 ANDREW ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>gastro intestinal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis - cerebrovascular accidents</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dom.</u> 1959, to <u>3-19</u> 1961, that (I) (we) last saw the deceased alive on <u>3-13</u> 1961, and that death occurred at <u>1 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Russell M. Tilley, Jr.</u>				22b. ADDRESS <u>4701 - Max. Ave. N.W. D.C.</u>		22c. DATE SIGNED <u>3-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>RUSSELL M. TILLEY</u>				22d. ADDRESS <u>4701 - Max. Ave. N.W. D.C.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>March 22-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring - Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hatten</u>				25a. REC'D BY REGISTRAR <u>Arthur H. Hatten</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur H. Hatten</u>	

may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPT  
please a

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER:

This certificate should be executed within 24 hours after death. It an

is the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the f

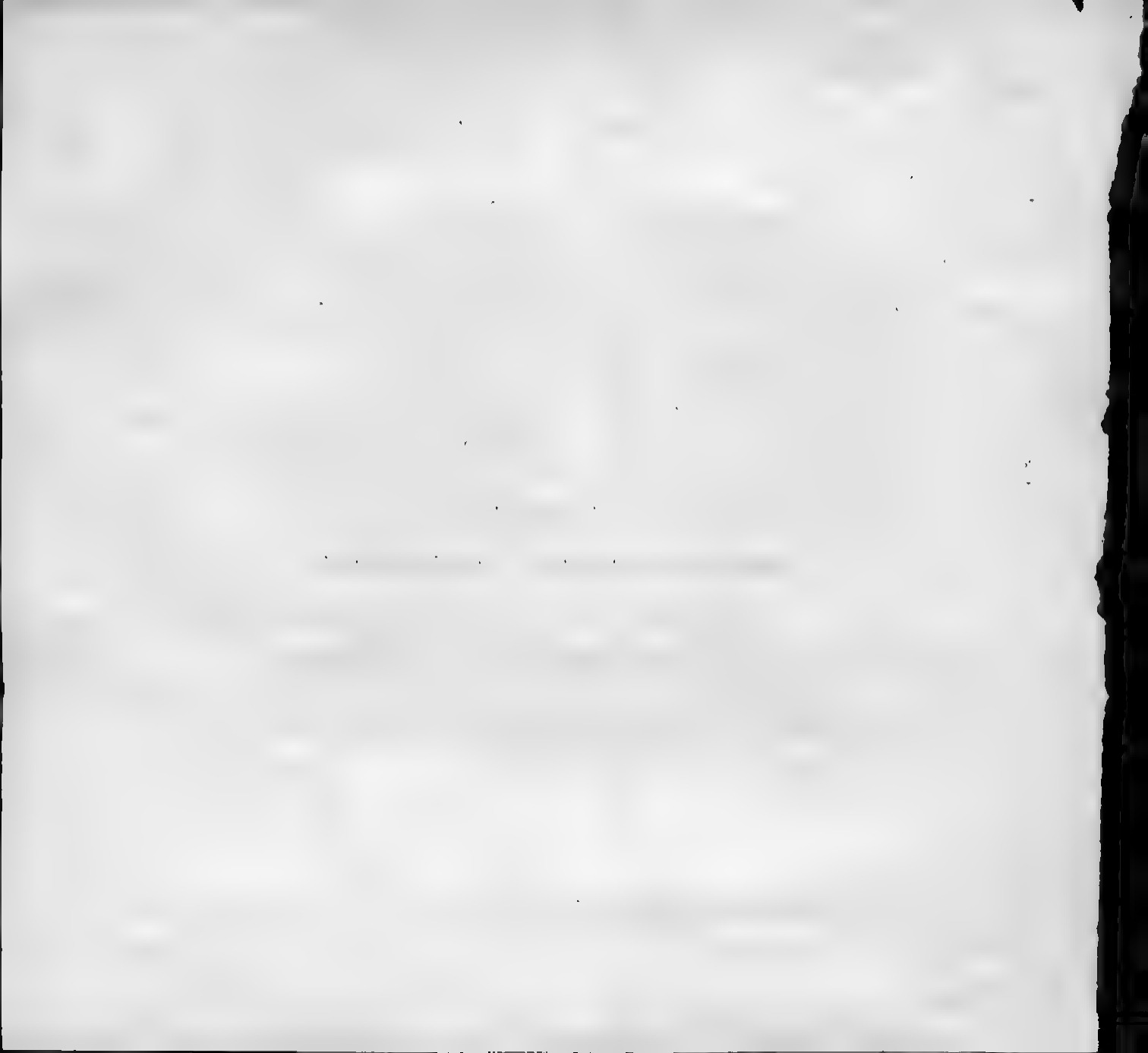
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FOR  
HEALTH

## 333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03319

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>815 S Slingshot St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. SAN &amp; Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Arthur Olsen</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-94</u> <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cabinet making</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLAF OLSEN</u>		14. MOTHER'S MAIDEN NAME <u>Gnette Samuelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service <u>yes 1st WW. 023-12-8089</u>		16. SOCIAL SECURITY NO. <u>MR Oliver Olsen</u>	
17. INFORMANT <u>Same as deceased</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u>			
DUE TO (b) <u>Severe coronary artery arteriosclerosis</u>			
DUE TO (c) <u>Severe myocardial hypertrophy with clinical hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. 19. WAS AUTOPSY PERFORMED? <u>Dislocation of the left elbow associated with auto accident</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>X</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>the driver of auto involved in accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. 3-7 1961</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <u>Street</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Silver Spring Monty Md</u>			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 8 1961</u>			
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>March 10, 1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Eastwood Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Lancaster, Mass.</u>			
23. FUNERAL DIRECTOR <u>J. Arthur Walters</u>			
ADDRESS <u>254 Carroll St NW D.C.</u>			
24a. REC'D BY REGISTRAR <u>MAR 10 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3332  
CERTIFICATE OF DEATH  
03320

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington D. C.	
c. LENGTH OF STAY IN TB 5 days		d. STREET ADDRESS 1629 Columbia Rd., Argoone Apt's	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Frank PADGETT		4. DATE OF DEATH Month Day Year March 18 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-80	
9. AGE (in years last birthday) 81 yrs		F UNDER 1 YEAR Months Days Hours MIN IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles PADGETT		14. MOTHER'S MAIDEN NAME Margaret Keyes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 17. INFORMANT Margaret P. STEPHAN 5304 Elliott Rd.	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis, cerebral (left middle cerebral) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 6 days years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>XXXXXX</del> attended the deceased from March 13, 1961 to March 18, 1961, that (I) <del>XXXX</del> saw the deceased alive on March 18, 1961, and that death occurred at 6:00PM from the causes and on the date stated above.			
22a. SIGNATURE Russell MILLER, Jr. LT, MC, USN		22b. DATE SIGNED 3-19-61	
22c. PHYSICIAN'S NAME (Type) Russell MILLER, Jr. LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley Funeral Home, Alexandria, Va.		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3333

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08321

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>16 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Kenneth Palmer</b>				4. DATE OF DEATH Month Day Year <b>March 1, 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 25, 1960</b>	
9. AGE (In years lost birthday) yrs <b>3</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>3 6</b>		11. IF UNDER 24 HRS Hours Min <b>6</b>		12. IF UNDER 1 YEAR Months Days Hours Min <b>3 6</b>	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Kenneth R. Palmer</b>				14. MOTHER'S MAIDEN NAME <b>Dixie Palmer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>The Medical Records The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO (b) <b>Pulmonary Congestion</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Acute congestive failure following aortic-pulmonary anastomosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 hour</b> <b>12 hours</b> <b>24 hours</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)				20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <b>February 13 19 61</b> , to <b>March 1 19 61</b> , that (he) (we) last saw the deceased alive on <b>March 1 19 61</b> , and that death occurred at <b>7:35 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. W. GILBERT</b>				22b. DATE SIGNED <b>3/2/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. W. GILBERT, M.D.</b>				22d. ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIPRA</b>				23b. DATE THEREOF <b>3-3-1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>SPARTA</b>				23d. LOCATION (City, town, or county) (State) <b>111</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. L. CHAMBERS CO</b>				25a. REC'D BY REGISTRAR <b>MAR 3 '61</b>			
ADDRESS <b>1400 CHAPIN ST</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

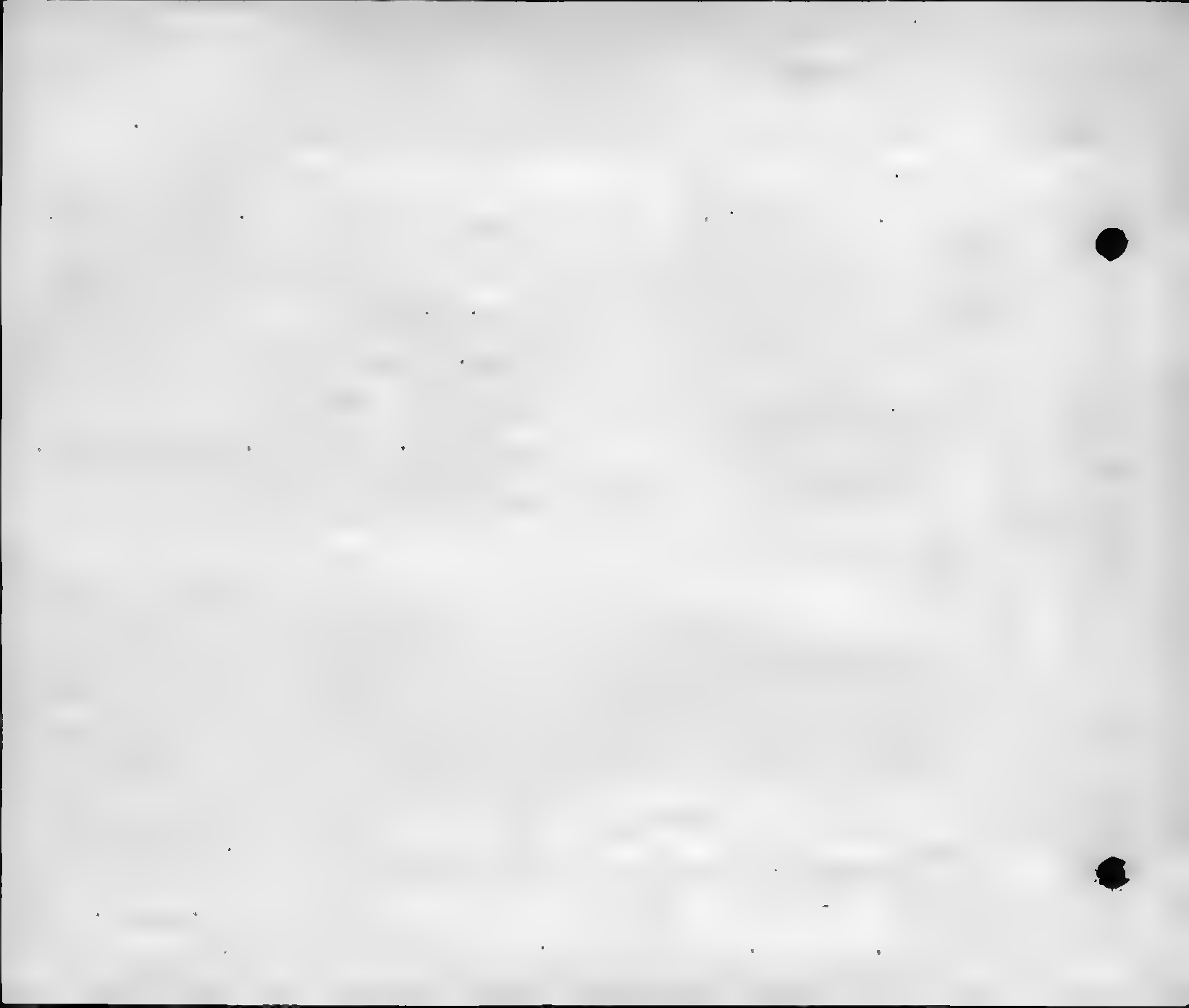
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03322

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>20yrs</u>		d. STREET ADDRESS <u>426 N. Frederick Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>426 N. Frederick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel Harold Peddicord</u>		4. DATE OF DEATH <u>March 14 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gardiner</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E. Peddicord</u>		14. MOTHER'S MAIDEN NAME <u>May allen Briggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Harold U. Peddicord. Rockville, Md.</u>	
17. INFORMANT <u>Harold U. Peddicord. Rockville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or country) (State) <u>Gaithersburg. Md.</u>	
23. FUNERAL DIRECTOR <u>Ernest C. Gartner. Gaithersburg. Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and return it to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

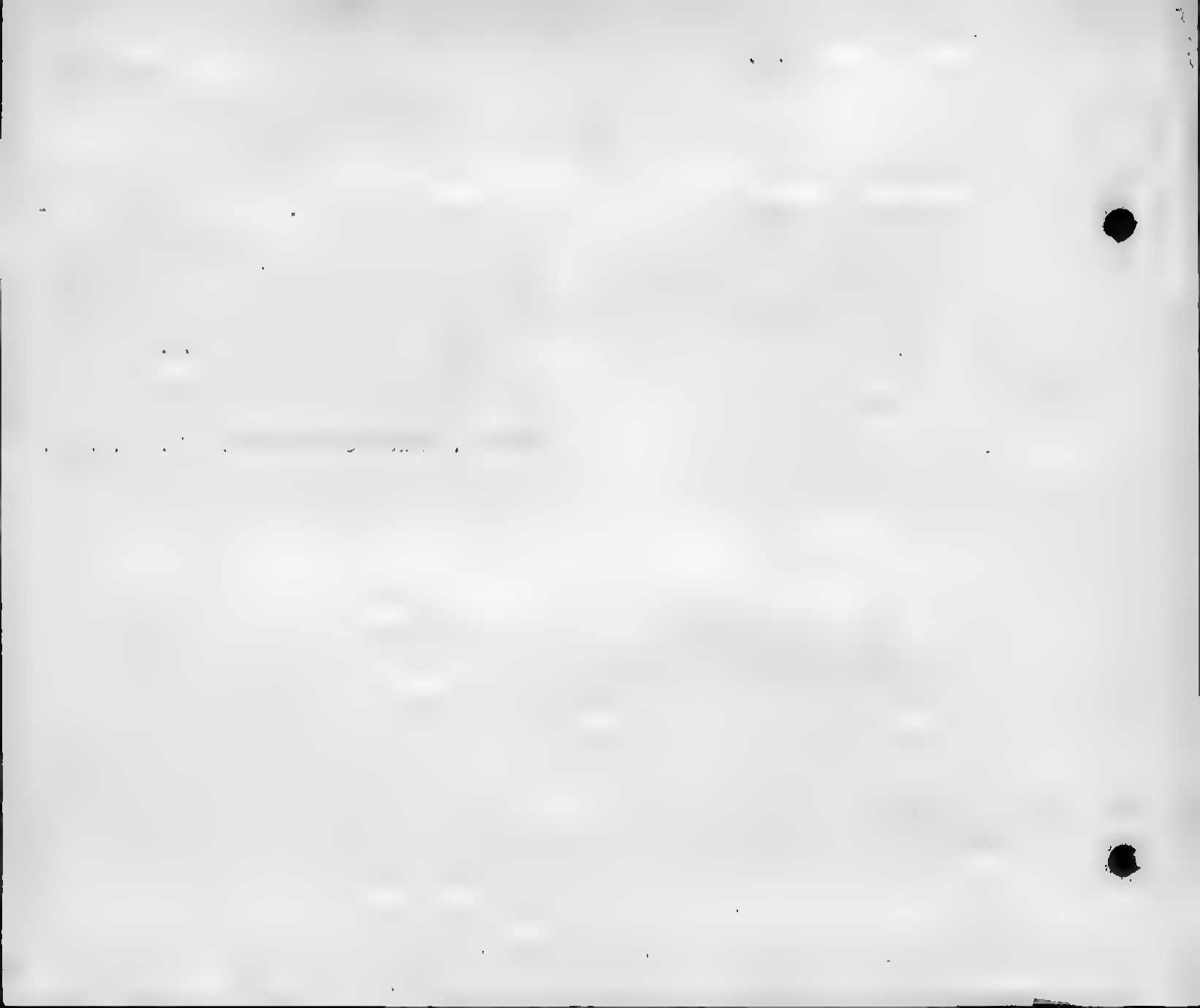
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3335

03323

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> c. LENGTH OF STAY IN lb <b>12 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WHEATON NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8031 EASTERN AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SHIRLEY</b> F rsr Middle Last 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>10/25/1903</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <b>57</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>RUSSIA</b> 11. BIRTHPLACE (Country & State, or foreign country) <b>U.S.</b> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>MAYER KERSUN</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <b>ISADORE A. PERRY 8031 EASTERN AVE., S.S., MD.</b> 17. INFORMANT <b>DORA CMINSKY</b> Address		14. MOTHER'S MAIDEN NAME <b>DORA CMINSKY</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS WITH INVOLVEMENT OF LEFT PLEURA, LIVER, AND SPLEEN, PRIMARY SITE UNDETERMINED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (the hospital) attended the deceased from <b>2/6 1961</b> to <b>3/29 1961</b> , that (I) (we) last saw the deceased alive on <b>3/28 1961</b> , and that death occurred at <b>9:54 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>David Goldenberg</b> M.D. 22b. DATE SIGNED <b>3/29/61</b> 22c. PHYSICIAN'S NAME (Type) <b>DAVID GOLDENBERG M.D.</b> 22d. ADDRESS <b>10620 GEORGIA, SILVER SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>3-31-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b> 23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH VA.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS - 3501-14th ST. N.W.</b> ADDRESS <b>APR 3 '61</b> 25a. REC'D BY REGISTRAR <b>APR 3 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3336

## CERTIFICATE OF DEATH

03324

<b>1. PLACE OF DEATH</b> COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY N 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4008 Quintana Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mabelle Louise Pfleger</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>8</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<b>8. DATE OF BIRTH</b> <u>Feb. 24, 1893</u>	
<b>9. AGE</b> (In years last birthday) <u>68</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bureau Engraving Wisconsin</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Charles A. Lanphear</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Pfuntner</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO</b> <u>215-14-7117</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE CORONARY, THROMBOSIS, ACUTE, LEFT ANTERIOR DESCENDING</u> DUE TO (b) <u>PULMONARY EMBOLISM, RIGHT AND LEFT LOWER</u> (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>				<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 WEEKS</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18, if either, NOTIFY MEDICAL EXAMINER)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>FEB. 11, 1961</u> <b>to</b> <u>MAR 3, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>MAR 7, 1961</u> , <b>and that death occurred at</b> <u>3:50</u> <b>AM</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert B. Irey</u>				<b>22b. DATE SIGNED</b> <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ROBERT B. IREY</u>				<b>22d. ADDRESS</b> <u>7105 Riggs Road, Hyattsville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>Mar. 11, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>National Memorial Park</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Falls Church, Virginia</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 13 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Kraus</u>							

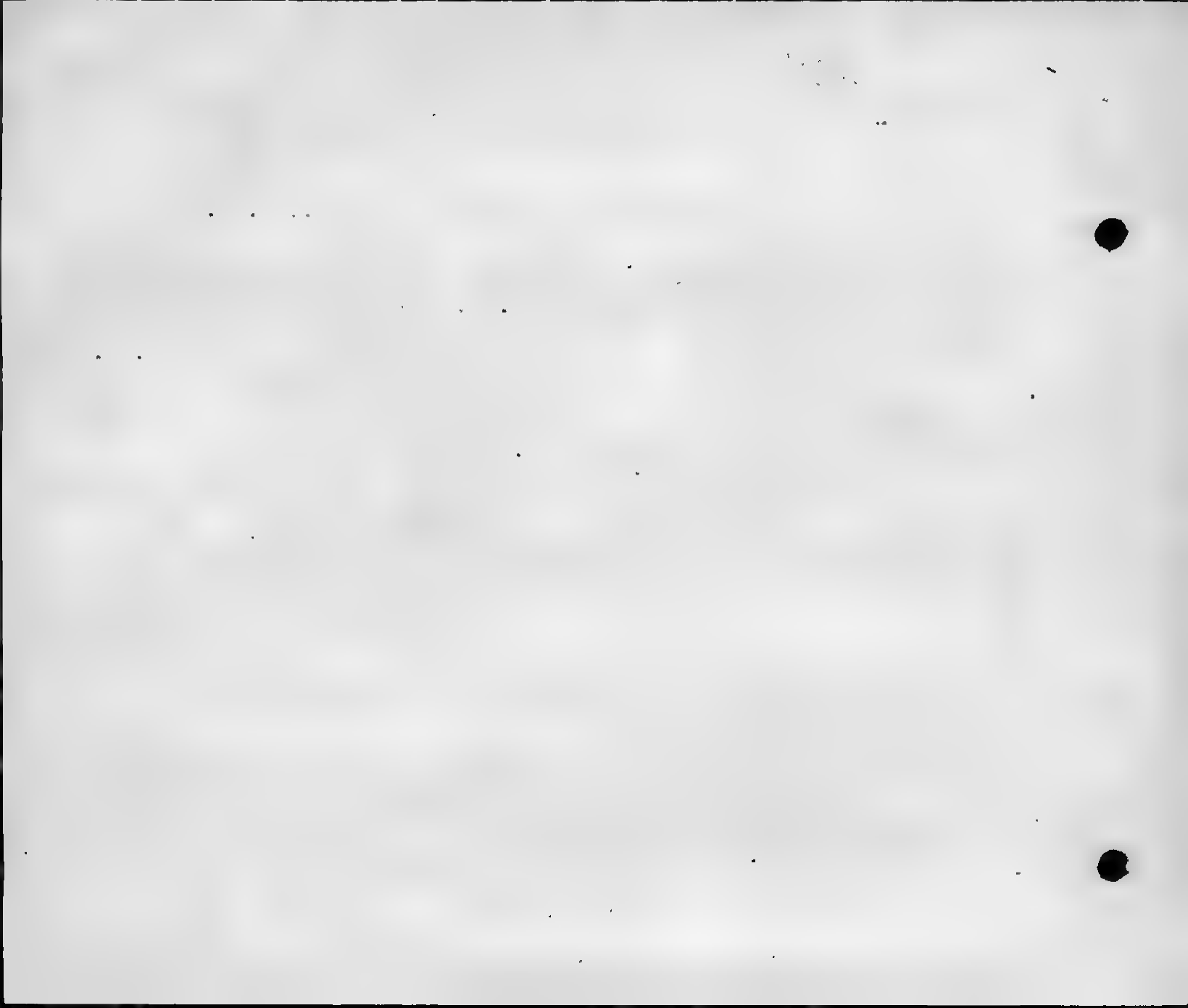


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Coroner notified and will approve.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
3337			
03325			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RLRA and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>District of Columbia</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> g. STREET ADDRESS <u>3517 Rodman St., N. W.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALLEEN</u> First Middle Last 4. DATE OF DEATH <u>MARCH 8 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 7, 1886</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u> 11. BIRTHPLACE (County & State or foreign country) <u>U. S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Alfred Owens</u> 14. MOTHER'S MAIDEN NAME <u>Frances Easterling</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Daughter</u> Address <u>Mrs. Frances Hoffheins</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>16 HOURS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3-8</u> <u>11:00 PM</u> <u>3-8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-8</u> <u>1961</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Edward W. Youngblood</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward W. Youngblood</u>		22b. DATE SIGNED <u>3-9-61</u> 22d. ADDRESS <u>Wisconsin &amp; Western Avenue, Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/11/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> 23d. LOCATION (City, town or county, (State) <u>Suitland, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>MAR 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



1  
FOR STATE  
HEALTH DEPT.

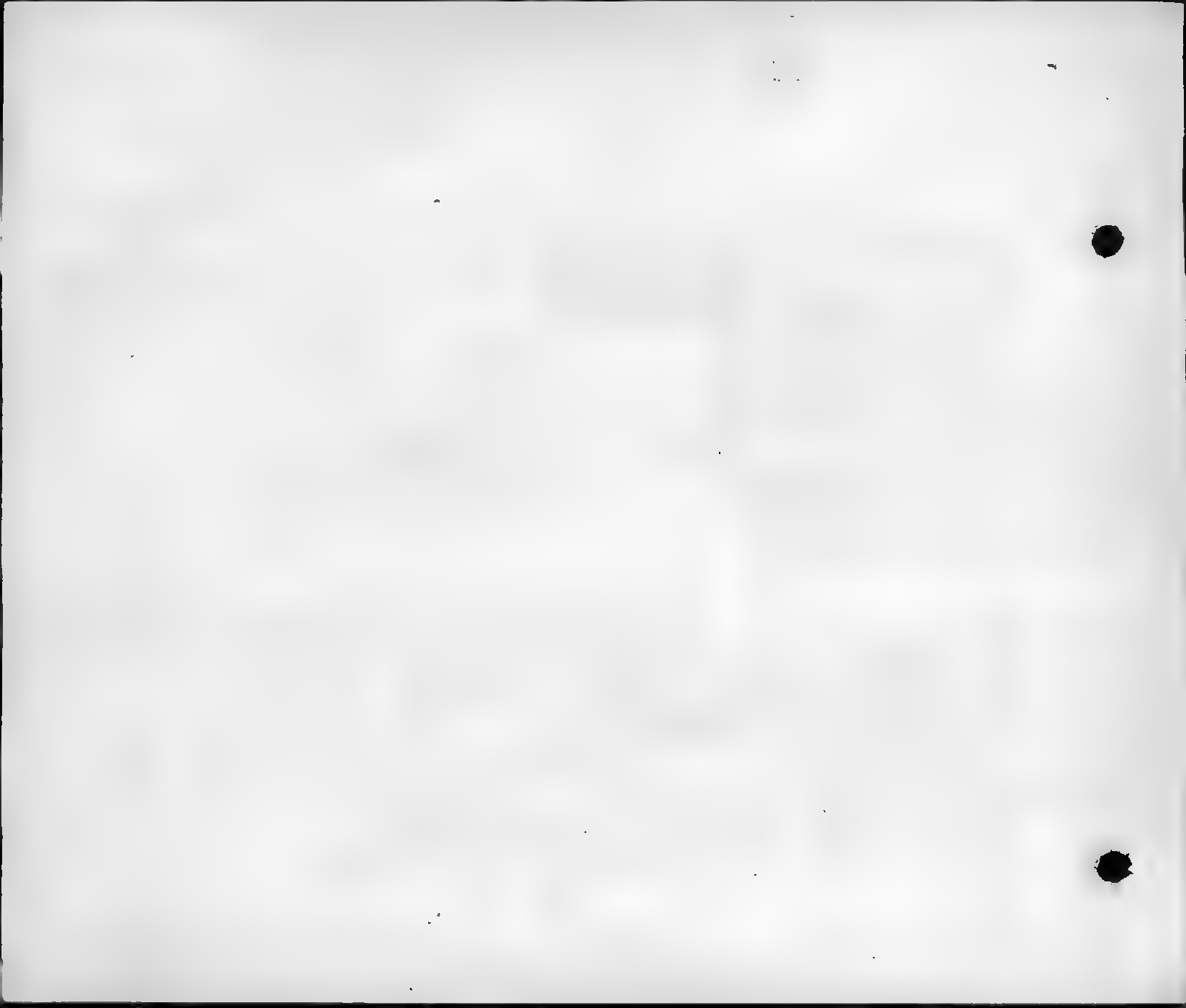
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3338

Item 7 filed 3-17-61 et

Reg. Dist. No. 03326

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11112 Mitschnr Street</b>		d. STREET ADDRESS <b>11112 Mitschnr Street</b>	
3. NAME OF DECEASED (Type or print) First <b>PATRICIA</b> Middle <b>ANN</b> Last <b>PHILLIPS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 8, 1925</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months <b>36</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Clarence Edward Frances</b>		14. MOTHER'S MAIDEN NAME <b>Mannix</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>235-30-1983</b>	
17. INFORMANT <b>Sister</b>		Address <b>Mrs. Curran</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Found on bedroom floor.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <b>3-8-61</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/11/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		DATE <b>MAR 14 '61</b>	



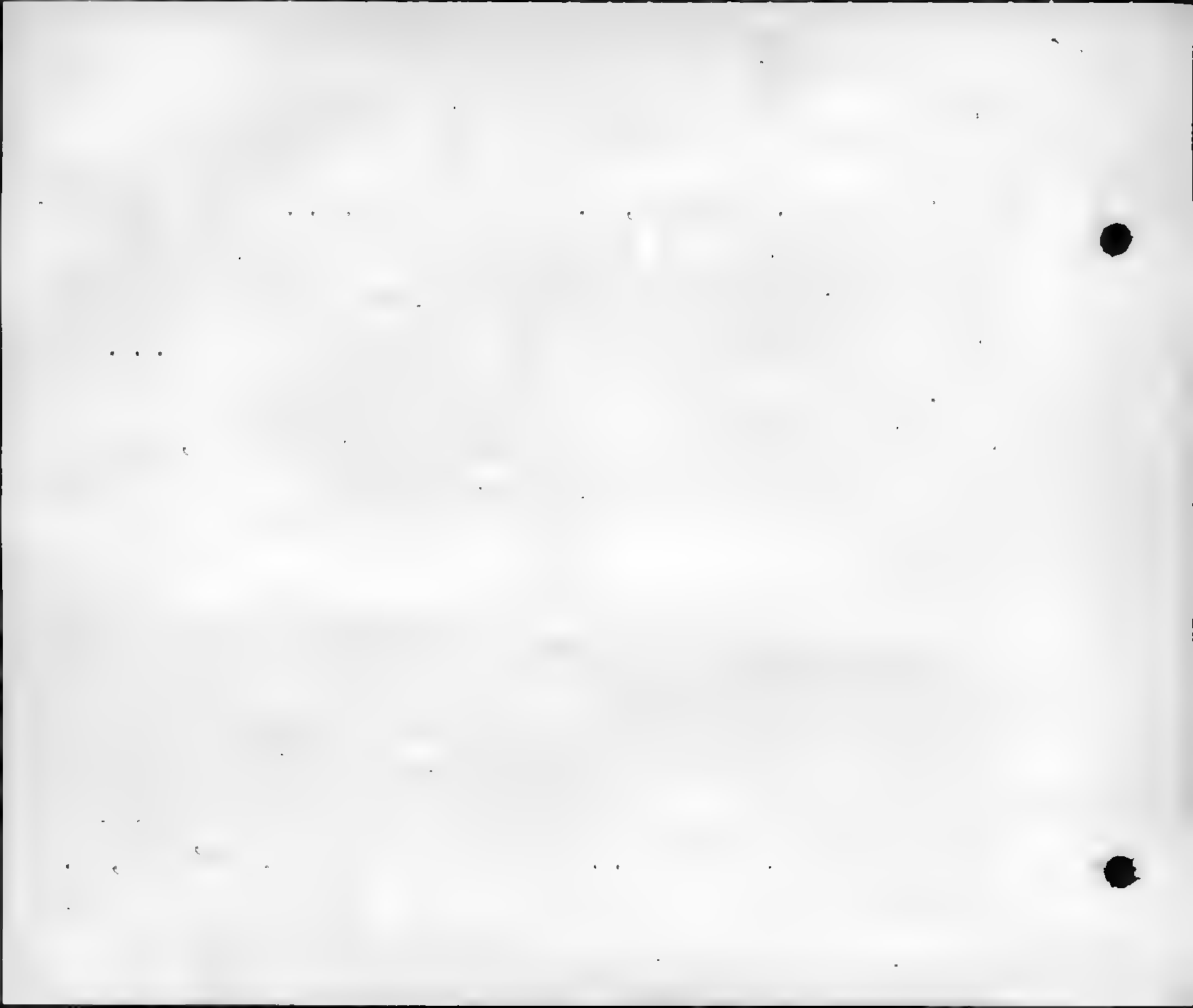
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3339

CERTIFICATE OF DEATH

03327

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>61 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>430 Ridge Road, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>May</b> Last <b>Phyfer</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 18, 1955</b>	
9. AGE (in years last birthday) yrs. <b>5</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Bill S. Phyfer</b>		14. MOTHER'S MAIDEN NAME <b>Barbara M. Lowman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neuroblastoma, Metastatic to Lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>18 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 27, 1961</b> to <b>March 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 29, 1961</b> , and that death occurred at <b>4:40 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Robert B. Scoggins, M.D.</b>				22b. DATE SIGNED <b>3-30-61</b>		22c. PHYSICIAN'S NAME (Type) <b>ROBERT B. SCOGGINS, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial-Transit 3/31/61</b>		23b. DATE THEREOF <b>3/31/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Albany Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>New Albany, Mississippi</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>				25c. DATE <b>APR 3 '61</b>			





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please advise the Director. Give Pages 1, 2, and 3 to the Deputy Medical Examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

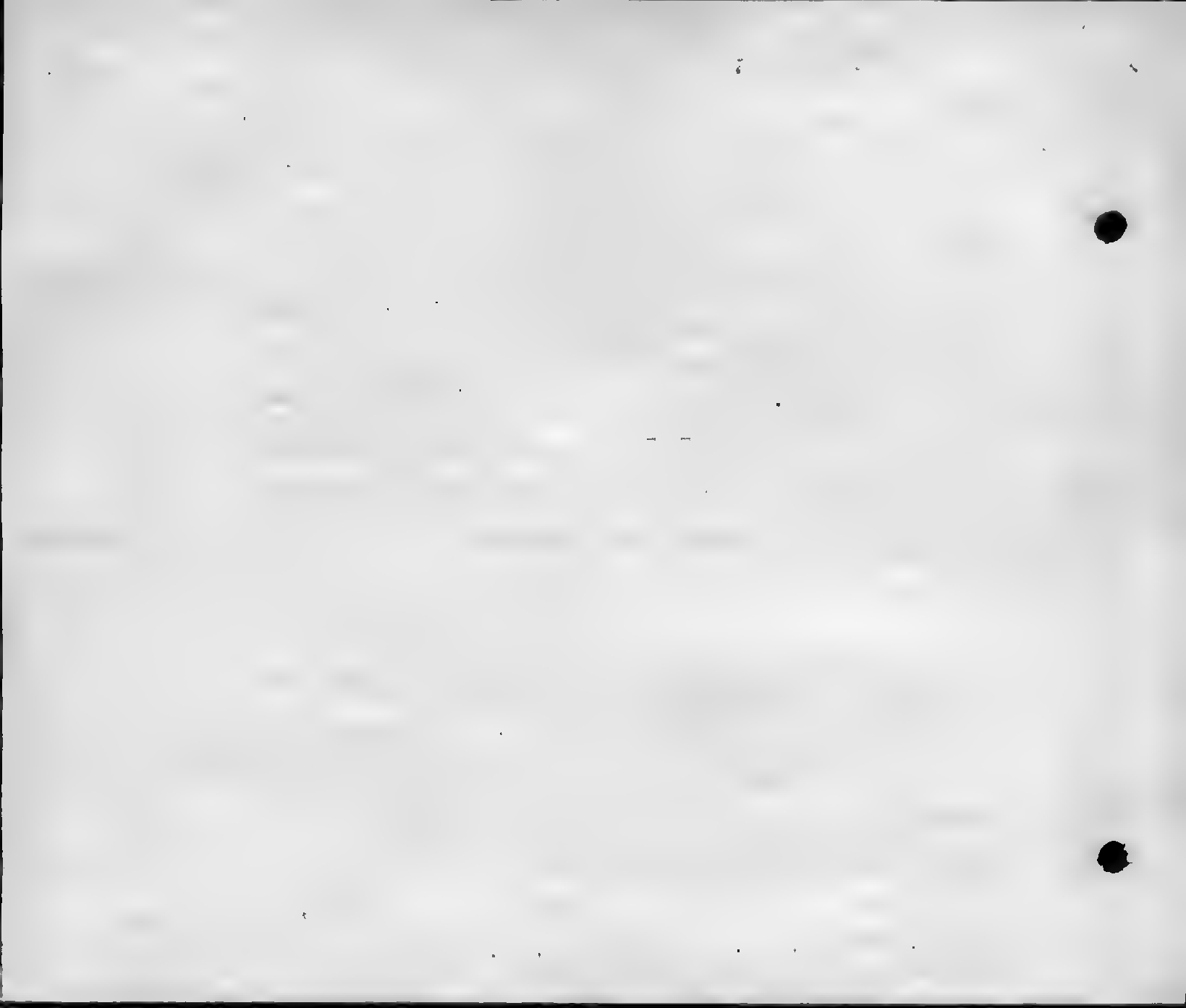
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# 3340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03328

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u></p> <p>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p> <p>c. LENGTH OF STAY in town <u>2 1/2 min.</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Maryland</u></p> <p>b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>3106 Weller Rd.</u></p> <p>d. STREET ADDRESS <u>34</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Daniel Beard Pinnell</u></p> <p>4. SEX <u>m</u></p> <p>5. COLOR OR RACE <u>w</u></p> <p>6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>7. AGE (In years last birthday) <u>47</u> yrs.</p> <p>8. DATE OF BIRTH <u>2-21-14</u></p> <p>9. AGE (In years last birthday) <u>47</u> yrs.</p> <p>10. BIRTHPLACE (State or foreign country) <u>W. Va.</u></p> <p>11. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>13. DATE OF DEATH <u>3</u> <u>9</u> <u>1961</u></p> <p>14. FATHER'S NAME <u>Joseph T. Pinnell</u></p> <p>15. MOTHER'S MAIDEN NAME <u>Willie Copanbauer</u></p> <p>16. SOCIAL SECURITY NO. <u>235-18-4325</u></p> <p>17. INFORMANT <u>Mrs Mildred Pinnell - wife</u></p> <p>18. ADDRESS <u>Same</u></p>	
<p>19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p> <p>20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage and massive laceration</u></p> <p>(b) <u>Bullet wound of the head</u></p> <p>(c) <u>1 hour</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9/16</u></p>			
<p>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p> <p>21b. TIME OF INJURY Month, Day, Year <u>8:55</u> <u>3-9</u> <u>1961</u></p> <p>21c. PLACE OF INJURY (Home, farm, factory, street, off co bldg., etc.) <u>Home</u></p> <p>21d. (City or town) <u>Washington</u></p> <p>21e. (County) <u>Montgomery</u></p> <p>21f. (State) <u>MD</u></p>		<p>22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>23. ACTUAL SIGNATURE <u>Frank J. Broschert</u></p> <p>24. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u></p> <p>25. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>26. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>27. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>28. DATE SIGNED <u>3-9-61</u></p>	
<p>29a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT &amp; BURIAL</u></p> <p>29b. DATE THEREOF <u>3/9/61</u></p> <p>29c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEMETERY</u></p> <p>29d. LOCATION (City, town, or country) <u>ALVON, WEST VIRGINIA</u></p>		<p>30. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC.</u></p> <p>31. ADDRESS <u>SILVER SPRING, MD.</u></p> <p>32. REC'D BY REGISTRAR <u>MAR 14 '61</u></p> <p>33. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u></p>	

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

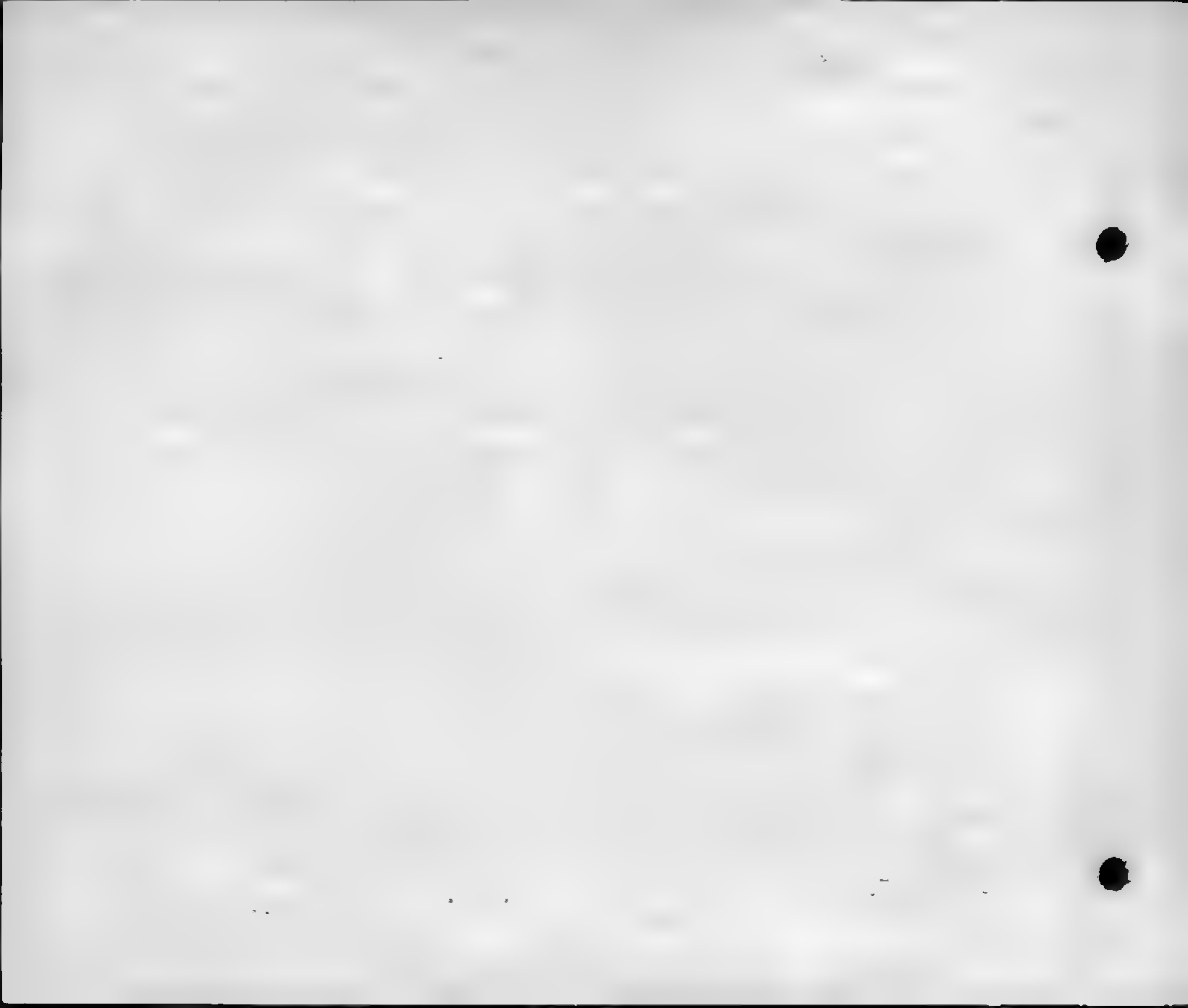
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
3341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		03329	
1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>28 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>11903 Dalewood Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Burt De Forrest Plumbadore</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 20, 1894</u> 67 yrs.
9. AGE (In years last birthday) <u>67</u> yrs.		10. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Watertown, N. York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Plumbadore</u>		14. MOTHER'S MAIDEN NAME <u>Florence Lowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.I.</u>	
17. INFORMANT <u>Host record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>1 hr.</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition <u>burial</u>		22b. DATE THEREOF <u>3/7/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Wash. N. Hine Co.</u>		24a. REC'D BY REGISTRAR <u>Wash. N. Hine Co.</u>	
24b. REGISTRAR'S SIGNATURE <u>Wash. N. Hine Co.</u>		DATE <u>MAR 7 '61</u>	

3-5-61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with  
page 3, and detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)  
15M 9/59



3342

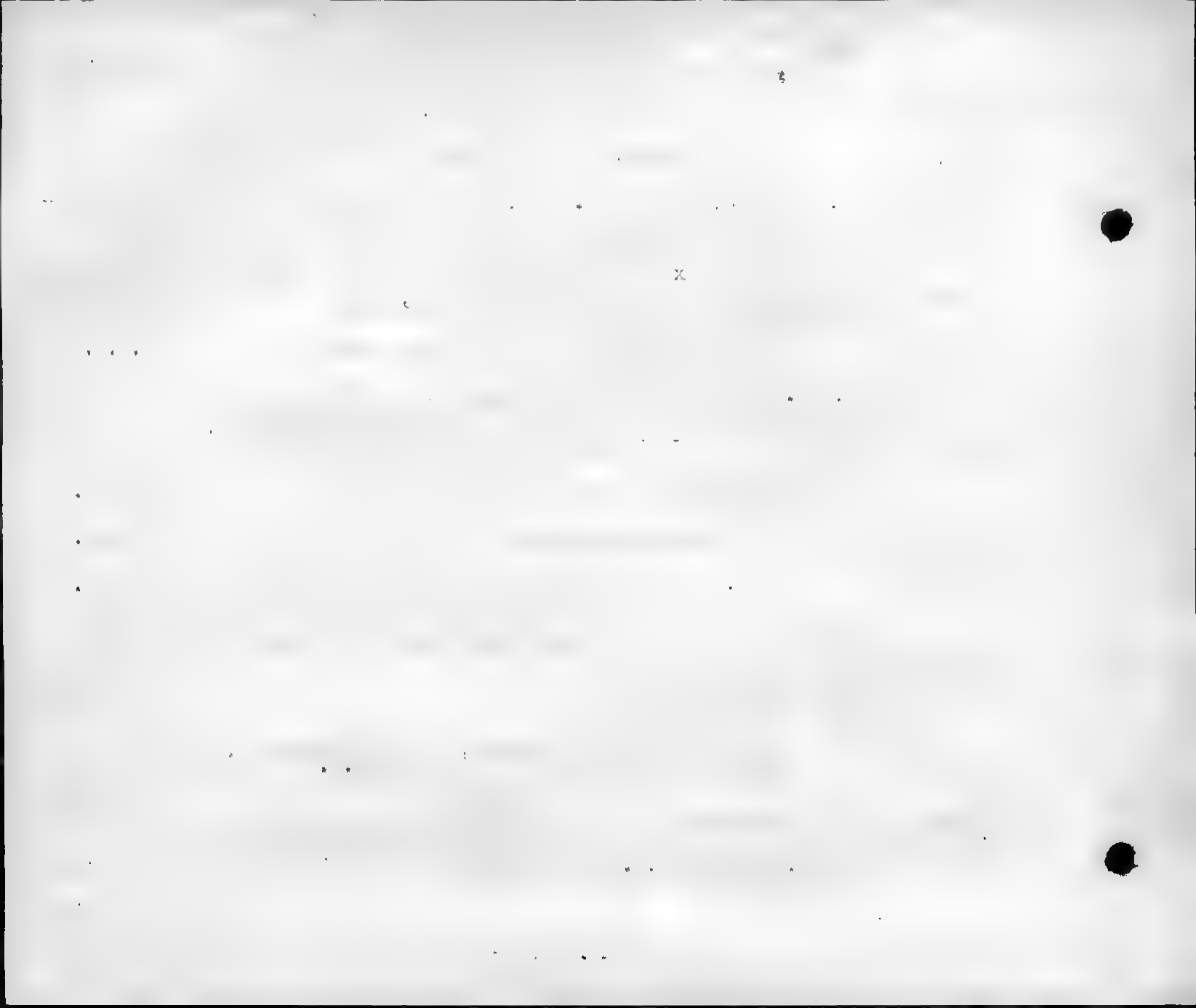
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03350

1. PLACE OF DEATH COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>18 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) STATE <b>Massachusetts</b> b. COUNTY <b>Millbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>12 Middleton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys Rosealene Poissant</b>		4. DATE OF DEATH Month Day Year <b>March 23 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>December 26, 1917</b>		9. AGE (In years last birthday) <b>43 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>3 yrs.</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Stamper, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Williamson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>031-18-3176</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral insufficiency</b> DUE TO (c) <b>Rheumatic Heart disease, inactive</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>6 yrs.</b> <b>36 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) '19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 5, 1961</b> to <b>March 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 23, 1961</b> , and that death occurred at <b>2:00 p.m.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>James L. Talbert</b> 22c. PHYSICIAN'S NAME (Type) <b>JAMES L. TALBERT, M.D.</b>		22b. DATE SIGNED <b>3/24/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>W. W. Chambers Co. 1400 Chapin St. Md.</b>		23d. LOCATION (City, town, or county) (State) <b>W. W. Chambers Co. 1400 Chapin St. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. 1400 Chapin St. Md.</b>		ADDRESS <b>W. W. Chambers Co. 1400 Chapin St. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

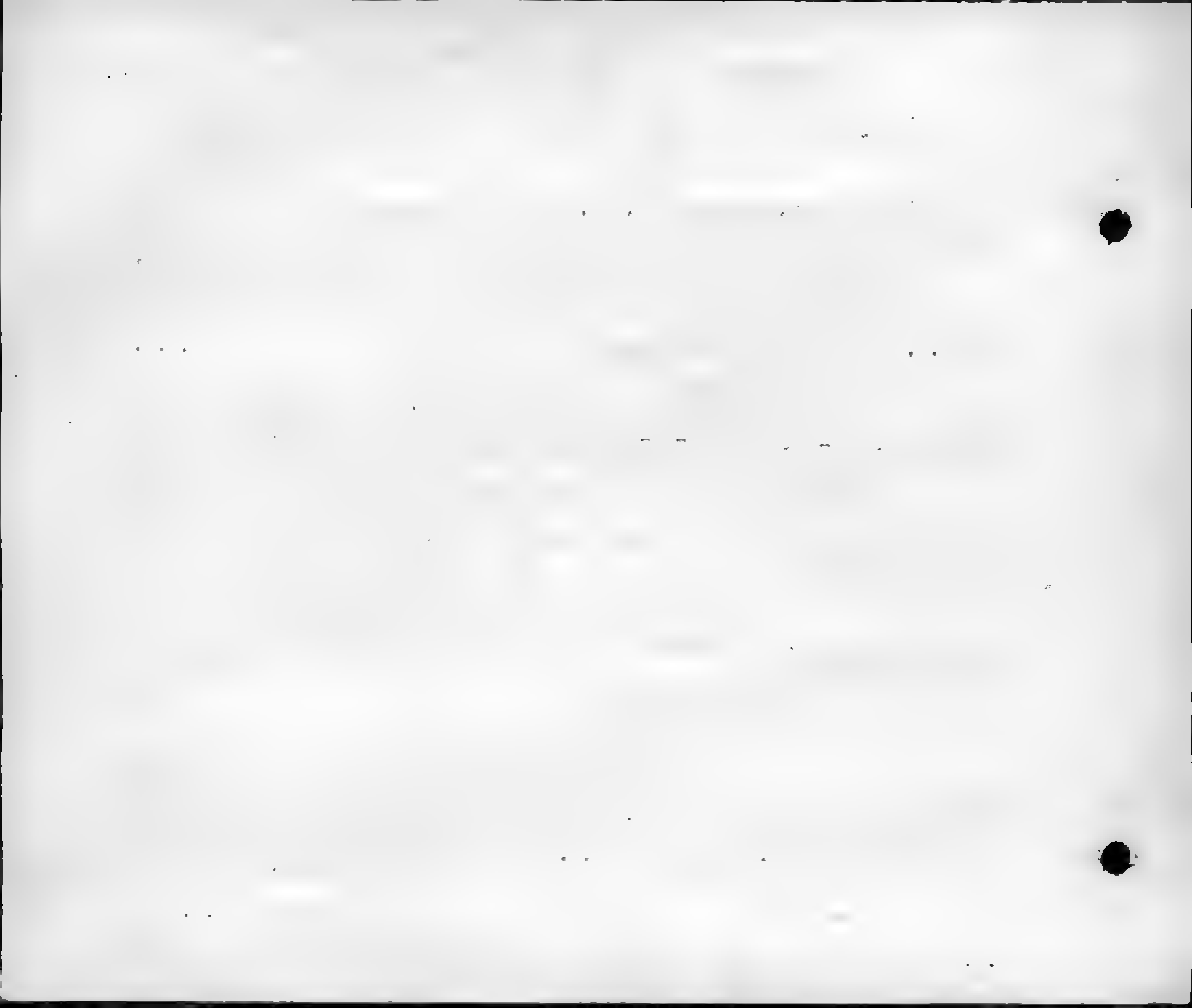
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3343

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03331

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HOWARD</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>138 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Underwood Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>Daniel</b> Last <b>Quesenberry</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1938</b>	9. AGE (In years lost birthday) yrs <b>22</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>A/2c U.S. Airforce</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Armed Forces</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fountain Quesenberry</b>				14. MOTHER'S MAIDEN NAME <b>Cornelia Hylton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1958 - 61</b>		17. INFORMANT <b>The Medical Records</b> address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>204.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Chronic Myelogenous leukemia</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>  <b>2 Years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 24, 1960</b> to <b>March 11, 1961</b> that (I) (we) last saw the deceased alive on <b>March 11, 1961</b> and that death occurred at <b>1:25 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Richard E. Rieselbach</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>3/12/61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Richard E. Rieselbach M.D.</b>				22d. ADDRESS <b>National Institutes of Health The Clinical Center, Bethesda 14, Maryland</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-16-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>Portsmouth, N.H.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3344

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

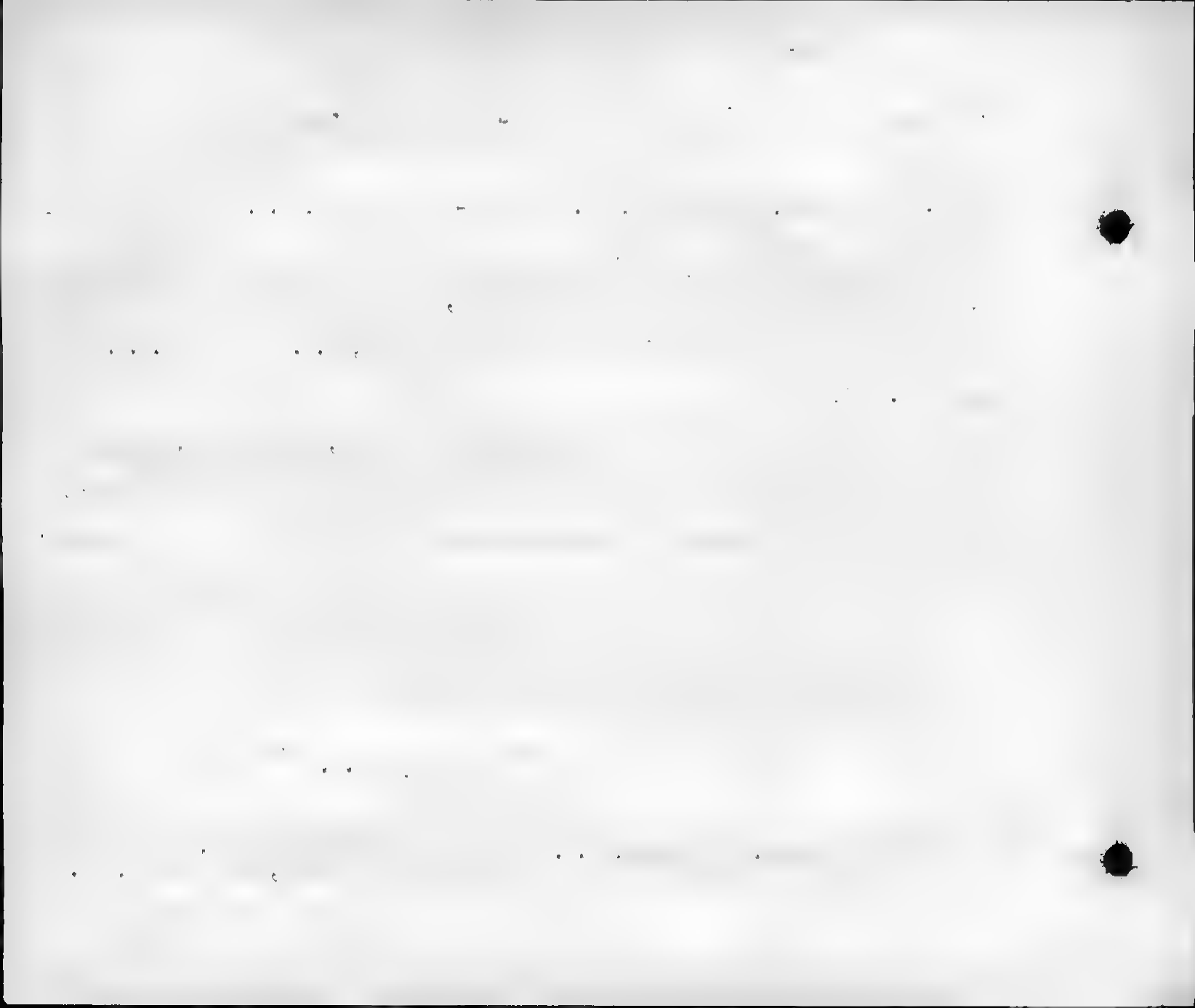
03332

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>30 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4964 - 12th Street, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Emmett Quirk</b>				4. DATE OF DEATH Month Day Year <b>March 8 1961</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 11, 1905</b>		9 AGE (In years last birthday) yrs <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael J. Quirk</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Mobley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service.) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 204 <b>204</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>1 1/2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 6, 1961</b> to <b>March 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 8, 1961</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard E. Reiselbach</b> M.D.				22b. PHYSICIAN'S NAME (Type) <b>RICHARD E. REISELBACH, M.D.</b>		22c. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL OR CREMATION <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> BURIAL		23b. DATE THEREOF <b>3-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 300-4th Street N.E.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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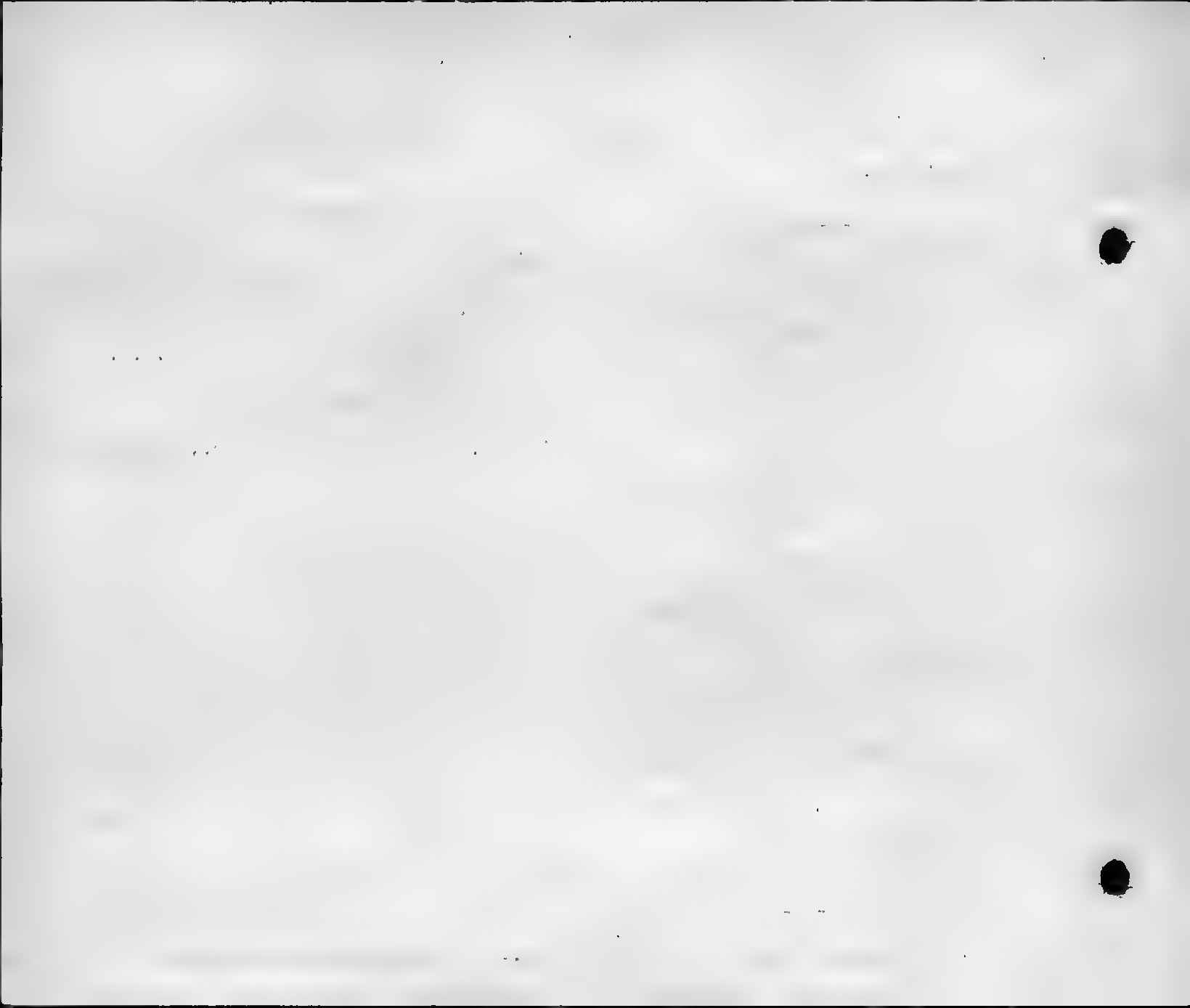


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death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 9/60

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>17</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Takoma Park</b>		d. STREET ADDRESS <b>113 Elm Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma Jane Raines</b>		4. DATE OF DEATH <b>March 19 1961</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 28, 1877</b>	
9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Elijah Raines</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Ellen Shakelford</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elton M. Raines</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis "generalized"</b> DUE TO (c) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. City or town <b>1957</b>		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11 Nov 1957</b> to <b>14 Mar 1961</b> that (I) (we) last saw the deceased alive on <b>17 Mar 1961</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Thomas P. Tagarty</b>		22b. DATE SIGNED <b>14 Mar 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Deal Funeral Home</b>		22d. ADDRESS <b>4812 Georgia Ave., NW</b>		22e. REC'D BY REGISTRAR <b>22 Feb 61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION (City, town or county) <b>Suitland, Maryland</b>		23e. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>		23f. REGISTRAR'S SIGNATURE	



## CERTIFICATE OF DEATH

Reg. Dist. No. 03364

3346

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville- Rural</b>		c. LENGTH OF STAY IN 1b <b>4 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Matthews Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>M.</b> Last <b>Reddick</b>		4. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29 1869</b>
9. AGE (In years lost birthday) <b>91 yrs</b>		10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>28</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Spurrier</b>		14. MOTHER'S MAIDEN NAME <b>Martha Biggs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Claude Reddick</b>		Address <b>Poolesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>10 years</b> (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 October, 1952 to 28 March, 1961</b> , that I last saw the deceased alive on <b>27 March 19 61</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b> DATE SIGNED <b>29 March 61</b>	
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		<b>Barnesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>3/31/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		ADDRESS <b>Barnesville, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Howard</b>	

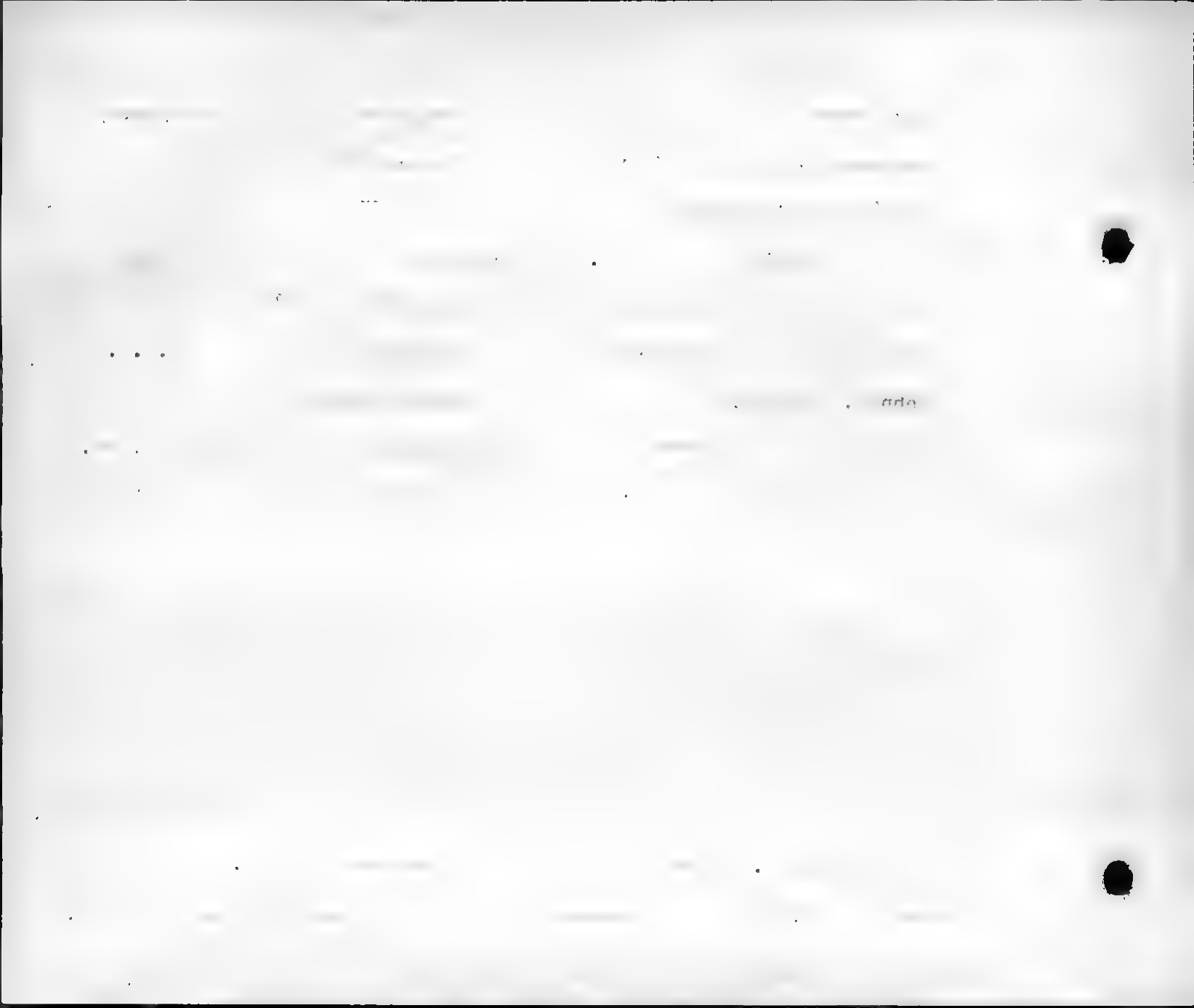
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 03335

3347

Arthur S. Kraus

VR A15 (4)  
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

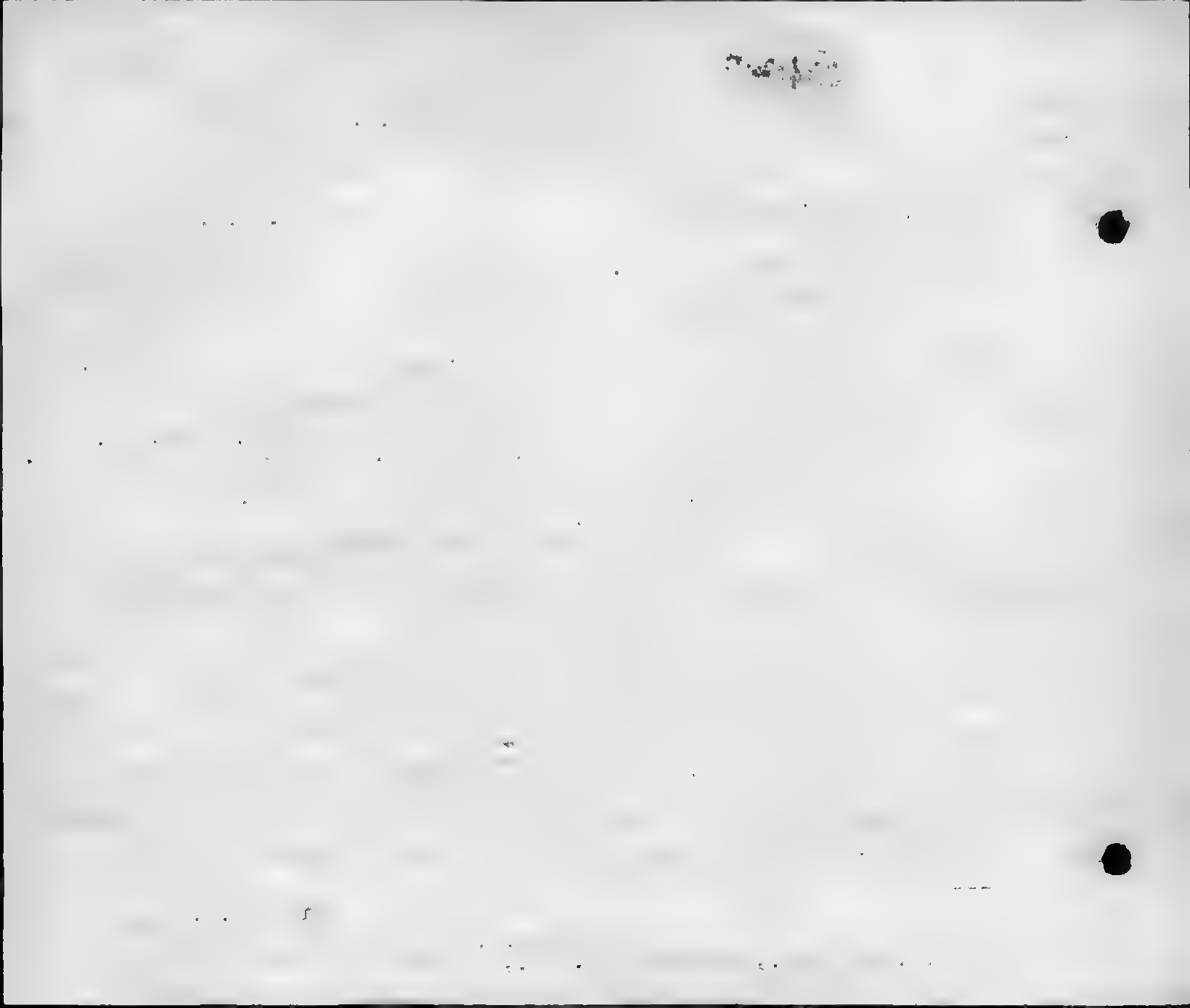
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3348

03336

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>3247 Chestnut St. N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Julie L. Reynolds</b>		4. DATE OF DEATH <b>March 16 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Denmark</b>	
13. FATHER'S NAME <b>Jacob Nilsson</b>		14. MOTHER'S MAIDEN NAME <b>Olene Hansen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Mrs. Dorothy R. Donegan</b>		18. CAUSE OF DEATH (Enter on only one cause per line for a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Malignant Vascular Thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Progressive Pulvic Phlebotrombosis 2° of Sepsis, from fall</b> causing the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Frozen Rt Hip joint</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days 3 wks.</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell 3rd. ago &amp; fract. Rt hip. Remained in traction since</b>	
20c. TIME OF INJURY Month, Day, Year <b>Feb 25 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Nursing Home (Resmor)</b>		20f. (City or town) (County) (State) <b>Washington D.C. Bethesda Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>March 16 1961</b> to <b>March 16 1961</b> , that (I) (we) last saw the deceased alive on <b>March 16 1961</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>James J. Foster</b>		22b. DATE SIGNED <b>3/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>TAMPO J. FOSTER</b>		22d. ADDRESS <b>1746 K St N.W.</b>	
23a. MANNER OF REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>3/17/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Ithaca, N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.,</b>		25a. REC'D BY REGISTR. <b>MAR 17 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



may be obtained by the hospital or attending physician by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3349

CERTIFICATE OF DEATH

02337

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Warren</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional manor Sanitarium</b>				d. STREET ADDRESS <b>Front Royal</b>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>E</b> Last <b>Ridgeway</b>				4. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/20/1874</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Otha B Ridgeway</b>				14. MOTHER'S MARDEN NAME <b>Sarah Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>331</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO <b>Generalized arteriosclerosis.</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sec. minutes</b> <b>Many yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (c) <b>Recent amputation of rt. thigh - Dry gangrene of left foot due to arteriosclerosis of iliofemoral.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, if stated in Part I)		20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1961</b> to <b>March 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1961</b> , and that death occurred <b>March 10, 1961</b> from the causes and on the date stated above							
22a. SIGNATURE <b>George A. Gray, Jr.</b>				22b. ADDRESS <b>4740 Chevy Chase Dr. Chevy Chase, MD</b>			
22c. PHYSICIAN'S NAME (Type) <b>George A. GRAY, JR. M.D.</b>				22d. ADDRESS <b>4740 Chevy Chase Dr. Chevy Chase, MD</b>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FREDERICK BUR. GRD.</b>		23d. LOCATION (City, town, or county) <b>WARREN COUNTY VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>MADDOX FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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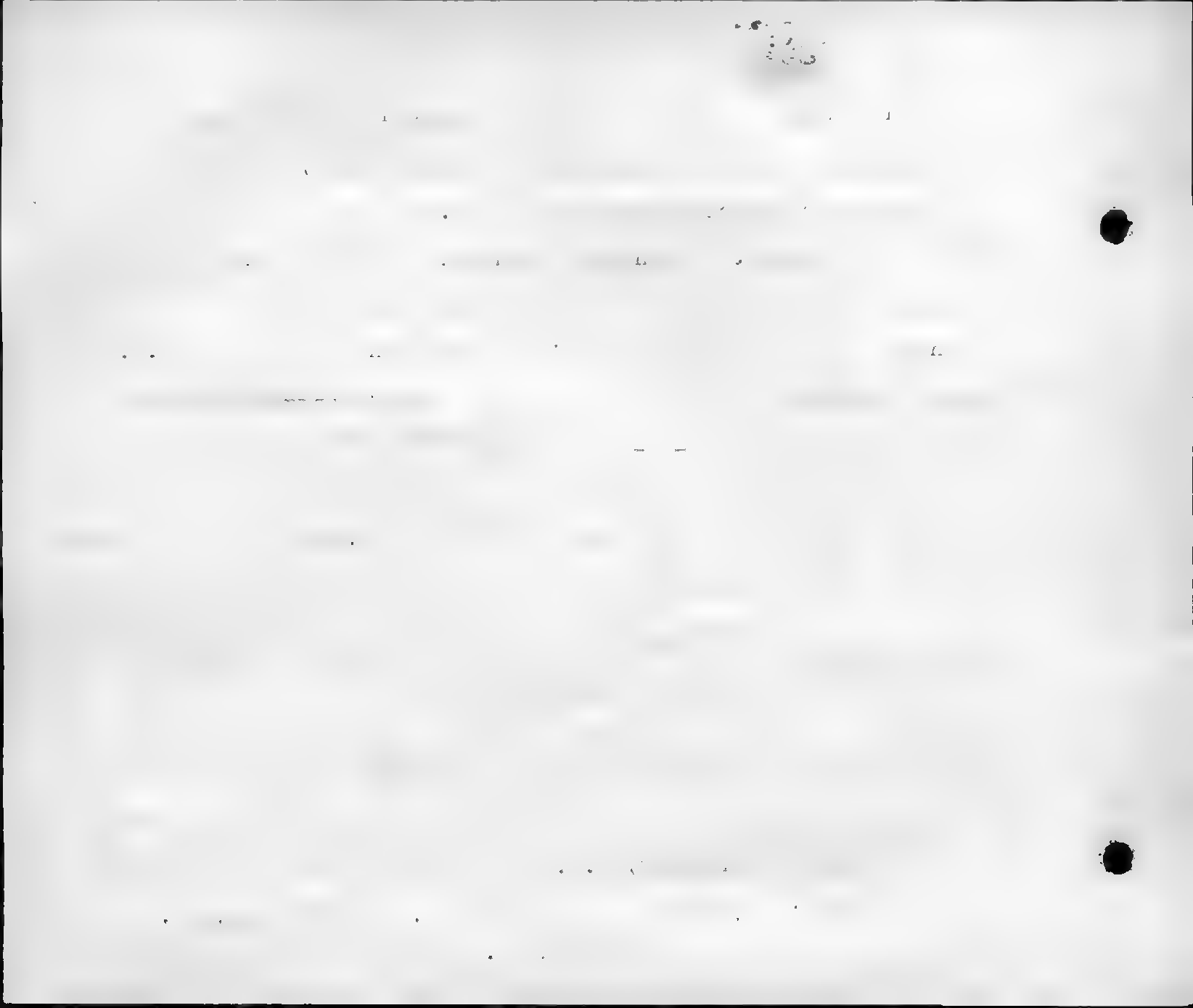
3350

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03338

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b (1)			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wilbur Stansbury Rinehart</b>				4. DATE OF DEATH Month Day Year <b>March 30 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/19/02</b>	
9. AGE (in years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School Buildings</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Lewis Rinehart</b>				14. MOTHER'S MAIDEN NAME <b>Antonia Ritchie Shocks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-01-6794</b>		17. INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420.1 DUE TO							<b>10 HOURS</b>
Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <b>PREVIOUS PARKINSONISM</b> DUE TO							<b>15 YEARS</b>
(c) <b>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE</b>							<b>15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD CEREBRAL THROMBOSIS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2011</b> , 1958 to <b>MARCH 30 1961</b> , that (I) (we) last saw the deceased alive on <b>MARCH 29 1961</b> , and that death occurred at <b>3:04 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Gordon Rosenberger</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>MARCH 30, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon Rosenberger, M.D.</b>				22d. ADDRESS <b>KUCKVILLE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 1, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth.</b>		23d. LOCATION (City, town, or County) (State) <b>Damascus, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Wolsanther</b>				ADDRESS <b>Damascus, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 4 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>			

MEDICAL CERTIFICATION



1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3351

CERTIFICATE OF DEATH

Reg. Dist. No. 03339

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedars of Lebanon Sanatorium, Wash.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eula Elizabeth</u> Middle <u>Robey</u> Last <u>Robey</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worked for Bureau of Engraving</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pomperet Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Henry J. Robey</u>			
14. MOTHER'S MAIDEN NAME <u>Higgie MARTIN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>I-R-V. NC. Robey - H 2d.</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>J. R. V. NC. Robey - H 2d.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420. Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December, 1957</u> to <u>3-28-1961</u> , that I last saw the deceased alive on <u>3-28-1961</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aldo Vacca</u>				M.D. <u>1429 University Blvd. W. Silver Spr.</u>			
PHYSICIAN'S NAME (Type) <u>Aldo VACCA</u>				DATE SIGNED <u>3-28-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-30-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>				24a. REC'D BY REGISTRAR <u>James T. Ryan, Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>James T. Ryan, Inc.</u>	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VE A15 (4)  
15M 9/60

3352

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

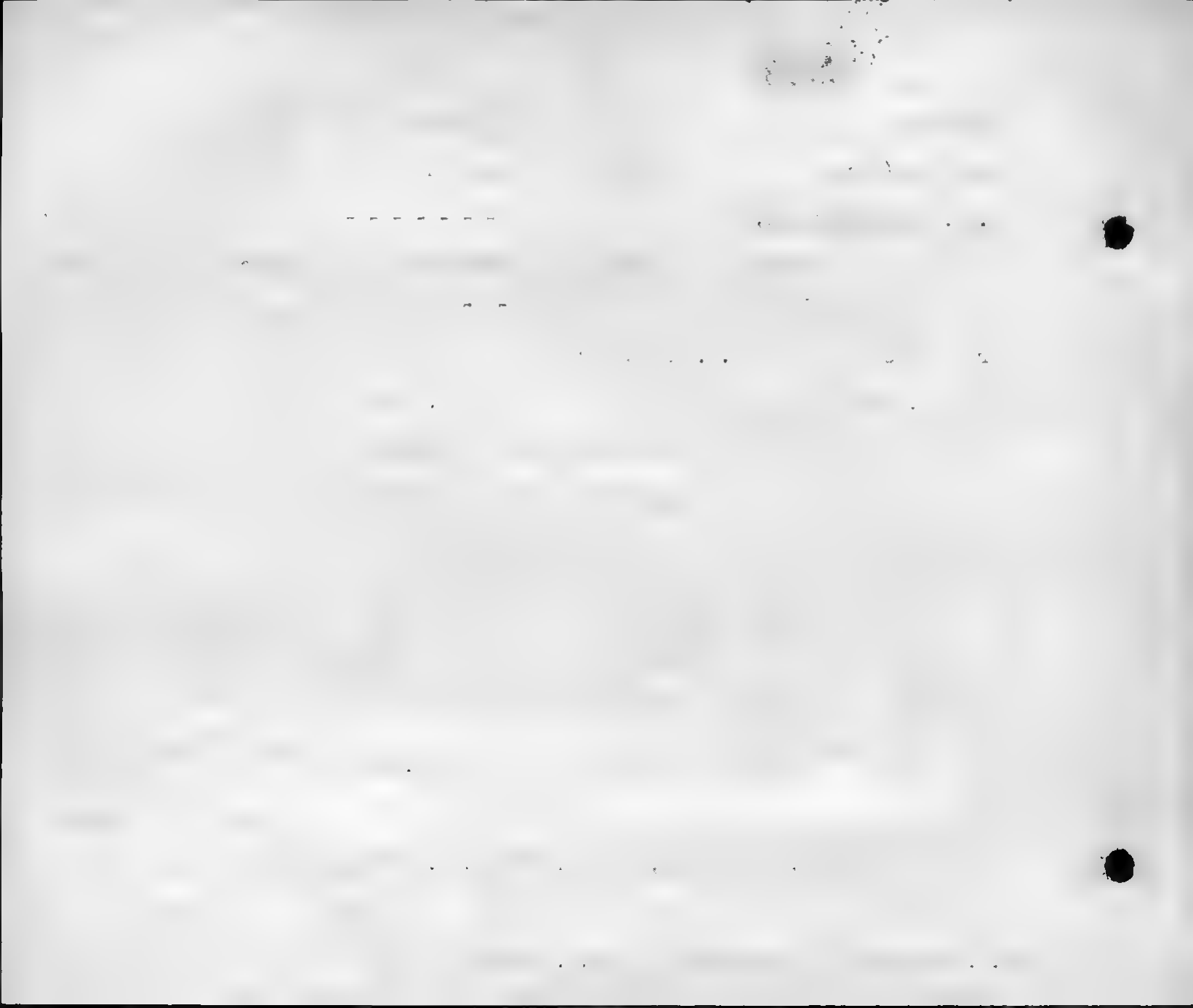
03340

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN b. <b>8 MO.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7520 - MAPLE AVE.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> d. STREET ADDRESS <b>7520 MAPLE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julia M. Rooney</b>		4. DATE OF DEATH <b>MARCH 24 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-24-75</b>
9. AGE (in years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>5</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL PITTS</b>		14. MOTHER'S MAIDEN NAME <b>Julia Mary White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>DOROTHY DOWD.</b>		Address <b>SAME AS #1</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>secondary vascular hemorrhage</b> (a), stating the underlying cause last, (c) <b>Advanced Arteriosclerosis</b> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1960</b> to <b>March 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 23, 1961</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert B. Frey</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Frey</b>		22d. ADDRESS <b>7105 Riggs Rd. Hyattsville Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-27-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Not Oldest Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		25. REC'D BY REGISTRAR <b>MAR 27 '61</b>	
ADDRESS <b>3821-14th N.W. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

22





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

VR A15 (4)  
15M 9/59

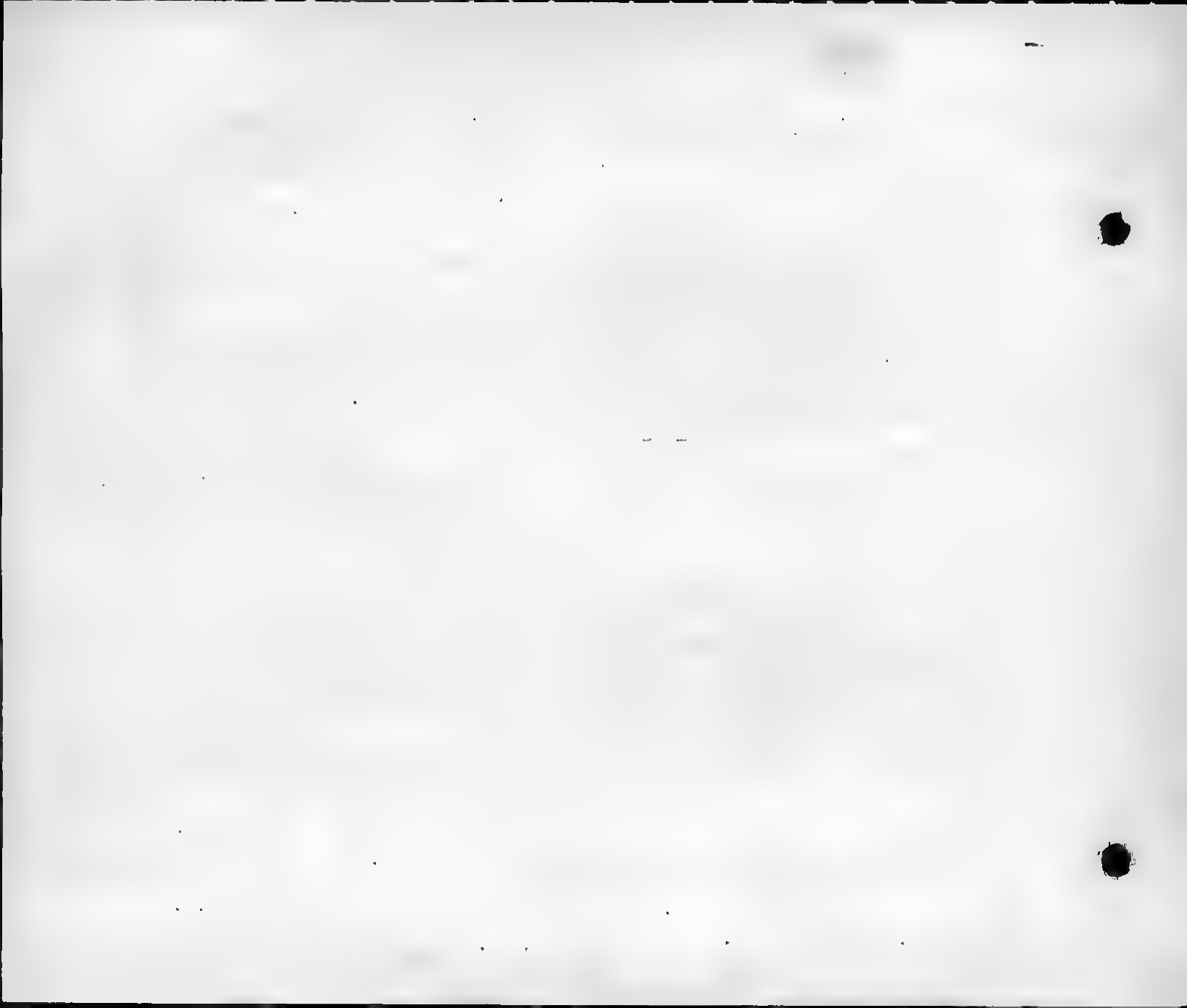
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8354

03342

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>2504 Seminary Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Joseph Ryder</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>John F. Ryder</u>		14. MOTHER'S MAIDEN NAME <u>Marye. Barry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-07-6451</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Tumor (malignant)</u> 1 <u>3.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>			
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-15-1960</u> to <u>3-14-1961</u> , that (I) (we) last saw the deceased alive on <u>3-13-1961</u> , and that death occurred at <u>1:19</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Marion Bankhead</u>		22b. DATE SIGNED <u>3/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md.</u>	
23a. BURIAL CREMATION <u>BURIAL</u> (Specify)		23b. DATE THEREOF <u>3/17/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Siska</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		25c. ADDRESS <u>SILVER SPRING, MD.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3355

03343

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY in 1b 6 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 5913 Johnson Ave

3. NAME OF DECEASED (Type or print)  
First Middle Last  
Beatrice H. Sadler

4. DATE OF DEATH  
Month Day Year  
March 13 1961

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH  
Month Day Year  
April 27, 1888

9. AGE (In years last birthday) 72 yrs. 10. UNDER 1 YEAR ☐ 11. IF UNDER 2 YRS. ☐ 12. CITIZEN OF WHAT COUNTRY? U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  
10b. KIND OF BUSINESS OR INDUSTRY -----  
11. FATHER'S NAME Sidney  
12. MOTHER'S MAIDEN NAME Boyle

13. WAS DECEASED EVER IN U.S. ARMED FORCES? No 14. SOCIAL SECURITY NO. Yes 15. INFORMANT Unknown  
Address Same as above

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease - Angina  
DUE TO 442X  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X  
b) Ischemic Heart Disease - Myocardial Infarction  
DUE TO Ischemic Heart Disease - Myocardial Infarction  
c) Ischemic Heart Disease - Myocardial Infarction  
INTERVAL BETWEEN ONSET AND DEATH 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hematoma  
17. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

18a. ACCIDENT WAS UNDERLYING ☐ 18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  
OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
3-7-61

19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 3-7-61  
20a. INJURY OCCURRED While at work ☐ Not While at work ☐  
20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20c. (City or town) (County) (State)

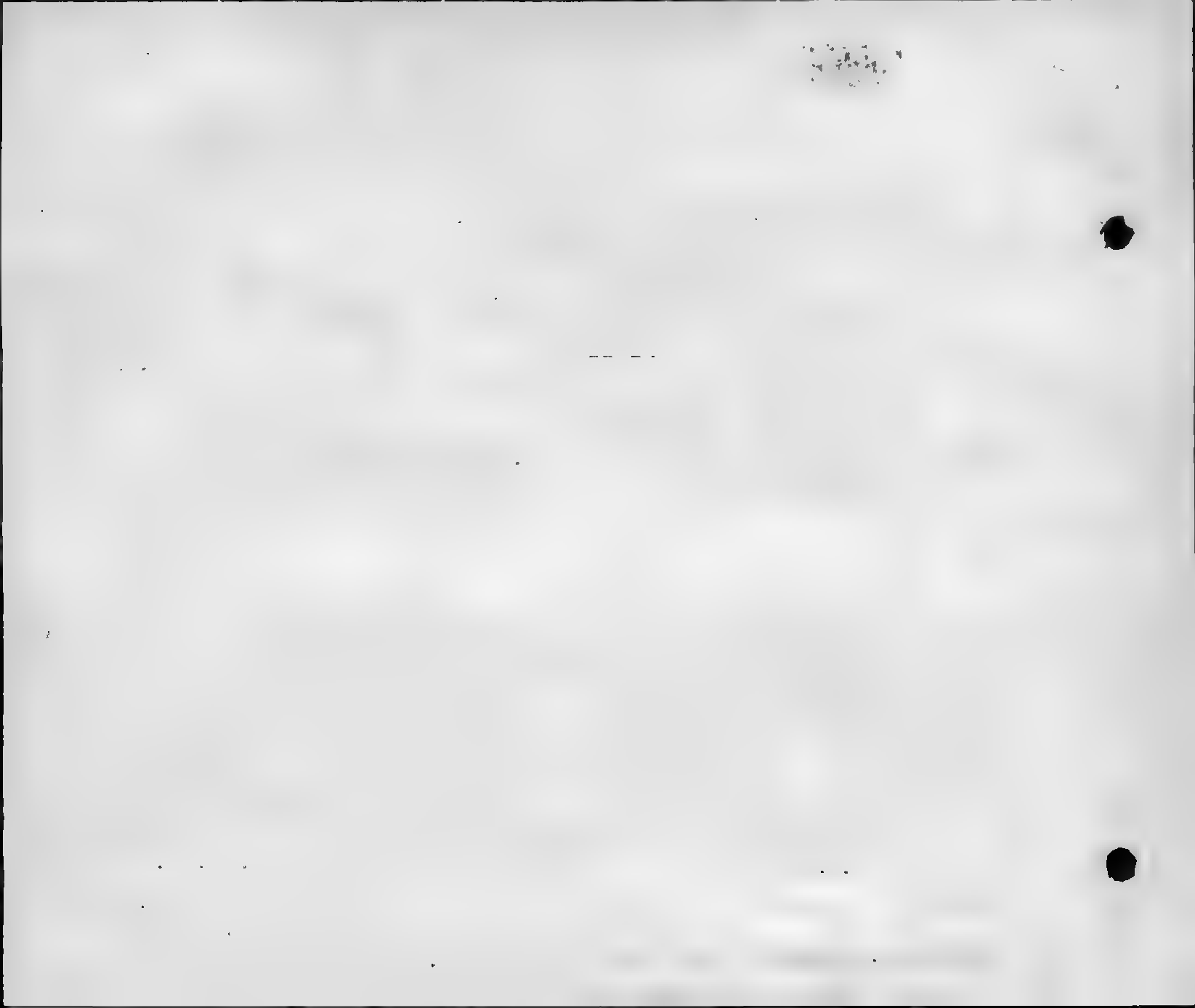
21. I certify that (I) (this hospital) attended the deceased from June 1950 to March 13, 1961, that (I) (we) last saw the deceased alive on 3-13-61, and that death occurred at 12:55 PM from the causes and on the date stated above.

22a. SIGNATURE P.P. Andrews M.D. 22b. DATE SIGNED 3-13-61  
22c. PHYSICIAN'S NAME (Type) P.P. Andrews  
22d. ADDRESS 4201 Fessenden St. N. W. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/16/61  
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City, town or county) (State) Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland  
25a. REC'D BY REGISTRAR DATE MAR 16 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3356

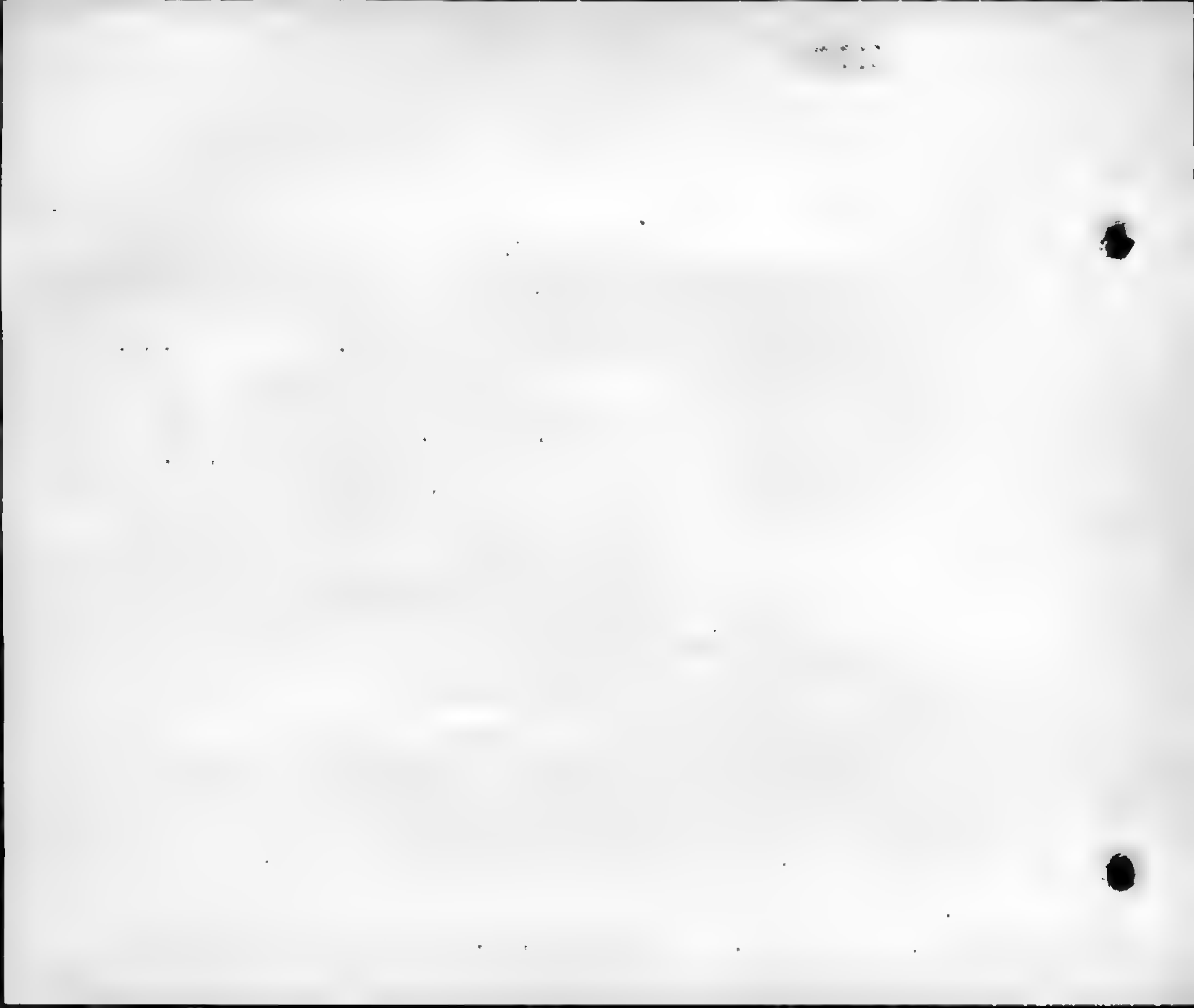
CERTIFICATE OF DEATH

03344

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FOREST GLEN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <b>LeDeau Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>DORA</b> Last <b>SAGE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/6/77</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES GUNTHER</b>				14. MOTHER'S MAIDEN NAME <b>ROSALIE unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Delmar W. Sage, 3217 Fayette Road Kensington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Diverticulitis, Severe</b> 8X DUE TO <b>Stasis, Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stasis, Colon</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left hemiplegia, old, stable</b>							INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Kensington, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1961</b> to <b>Mar 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 24, 1961</b> , and that death occurred at <b>1:15 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert T. Thibodeau</b> M.D.				22b. DATE SIGNED <b>Mar 25-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Thibodeau, M.D.</b>				22d. ADDRESS <b>10609 Concord St., Kensington, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>3/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>EVANSTON, ILLINOIS</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Brooks</b> INC.				25a. REC'D BY REGISTRAR <b>Mar 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1, 2, and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

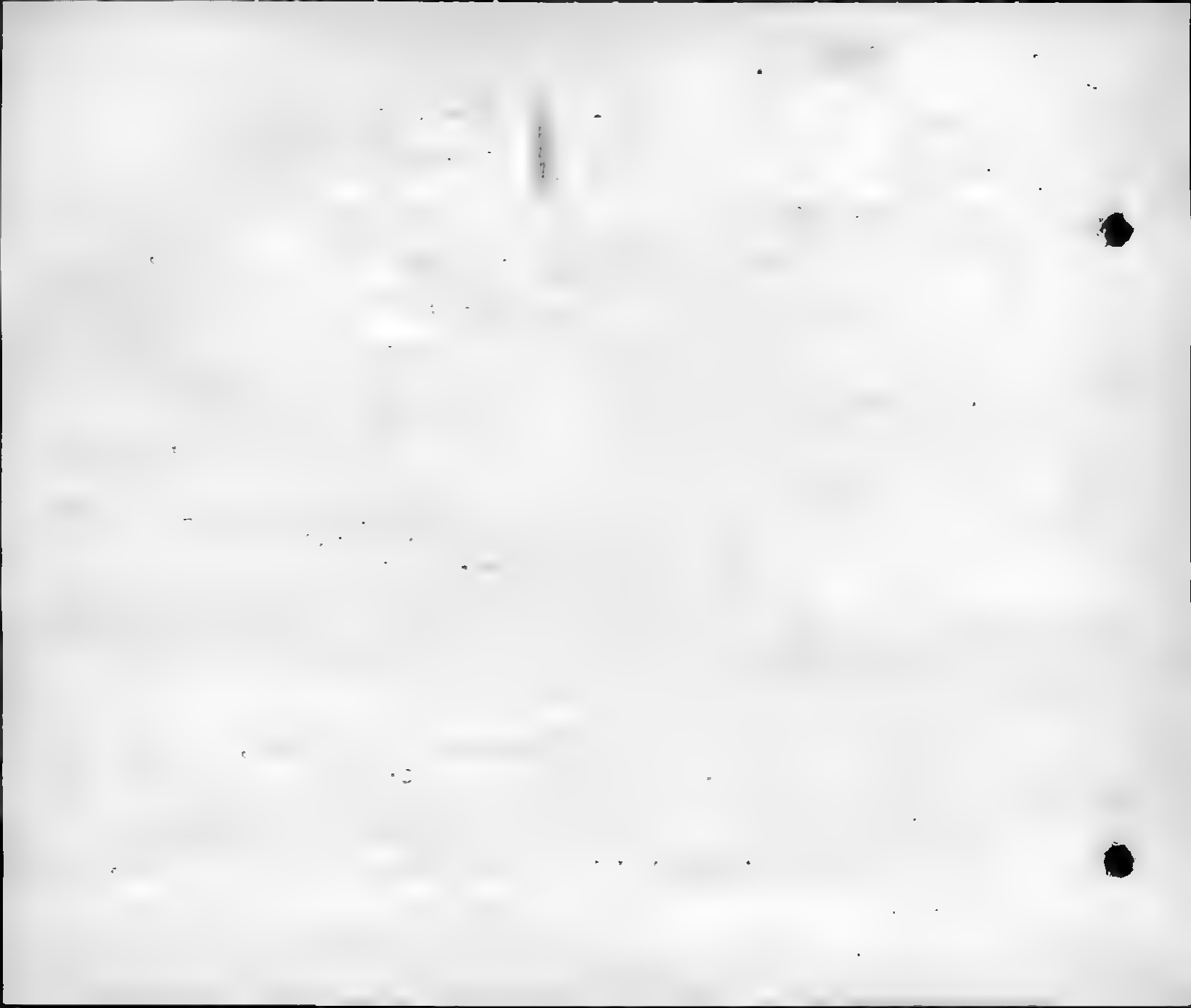
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3357

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03345

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>				d. STREET ADDRESS <b>General Delivery</b>			
3. NAME OF DECEASED (Type or print) First <b>Teresa</b> Middle <b>(None)</b> Last <b>Sampsell</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 61</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>August 8, 1960</b>		9 AGE (In years lost birthday) yrs <b>6</b>	IF UNDER 1 YEAR Months <b>22</b>	IF UNDER 24 HRS Hours <b>22</b> Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Roger Sampsell</b>				14. MOTHER'S MAIDEN NAME <b>Ruby Collins</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>Cyanotic congenital heart disease, Complete transposition of the great vessels; ventricular septal defect; patent ductus arteriosus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 months 22 days</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 months 22 days</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>February 23, 19 61</b> to <b>March 7, 19 61</b> that (I) (we) lost the deceased alive on <b>March 7, 19 61</b> and that death occurred at <b>10:45 AM</b> on the causes and on the date stated above							
22a SIGNATURE <b>Benson R. Wilcox M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>3/7/61</b>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <b>Benson R. Wilcox, M.D.</b>				22d ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county) (State)	
<b>Burial-transit</b>		<b>3-8-61</b>		<b>Nable Cemetery</b>		<b>Hazard, Kentucky</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a REC'D BY REGISTRAR DATE <b>MAR 10 '61</b>	
						25b REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3358

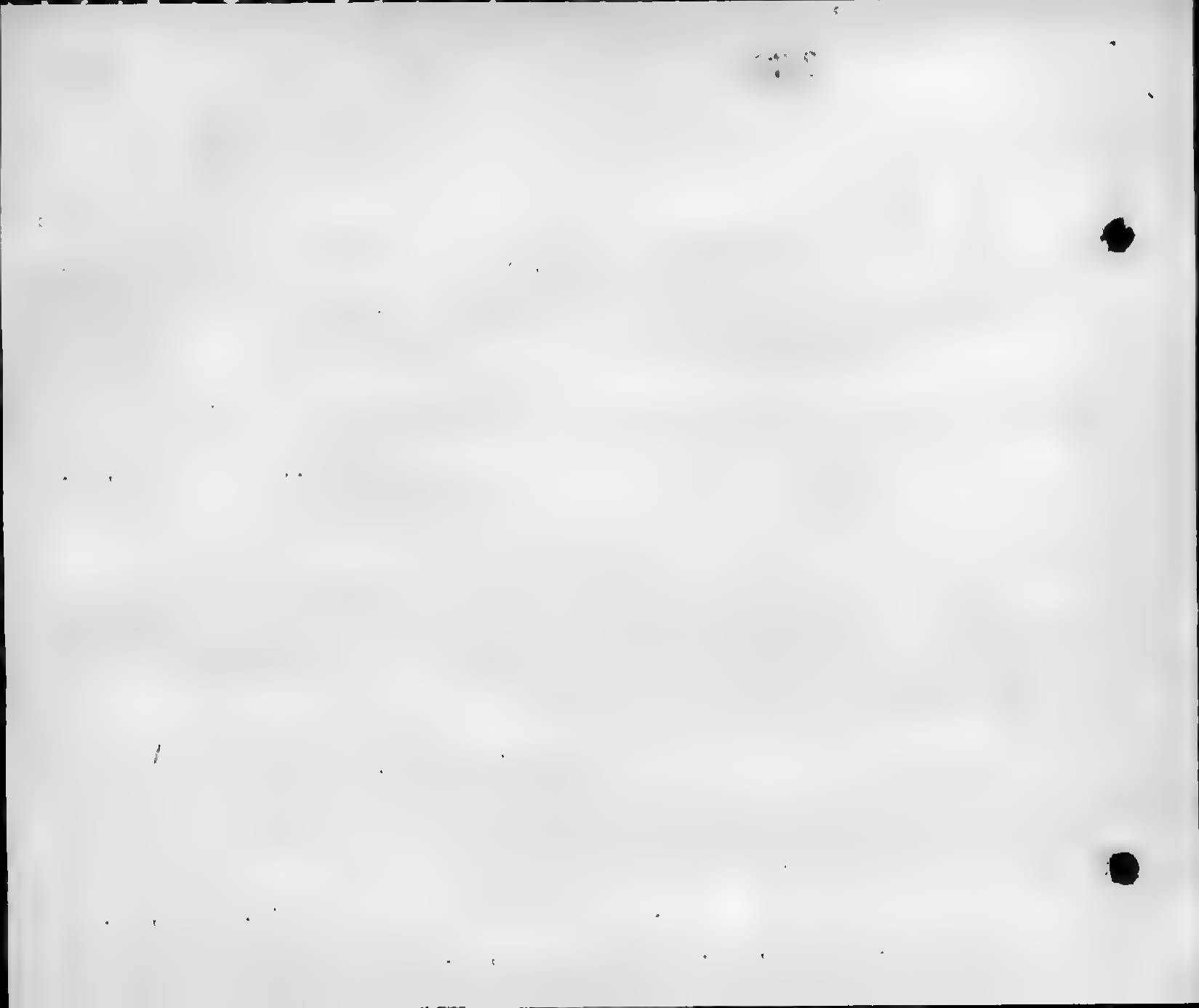
## CERTIFICATE OF DEATH

03346

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived; If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>SIX YEARS</b>		d. STREET ADDRESS <b>9603 Bristol Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9603 Bristol Avenue</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LYDIA JANE SAPHOS</b>		4. DATE OF DEATH <b>MARCH 22 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 16, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years last birthday) <b>70 yrs.</b>
11. BIRTHPLACE (County & State or foreign country) <b>CUMBERLAND, MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REAMER H. ALSIP</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE LOTER (deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-03-9608</b>	
17. INFORMANT <b>MR. STEPHEN SAPHOS</b>		Address <b>9603 Bristol Ave., Silver Spring</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER</b> Conditions, if any, which gave rise to immediate cause (b) <b>of UTERUS</b> (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1960</b> to <b>March 22, 1961</b> that (I) (we) last saw the deceased alive on <b>March 22, 1961</b> , and that death occurred at <b>11:03 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles J. Demas</b>		22b. DATE SIGNED <b>3-22-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES JOHN DEMAS</b>		22d. ADDRESS <b>1301 - Mass. Ave. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/24/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Zuck</b>		25a. REC'D BY REGISTRAR <b>MAR 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

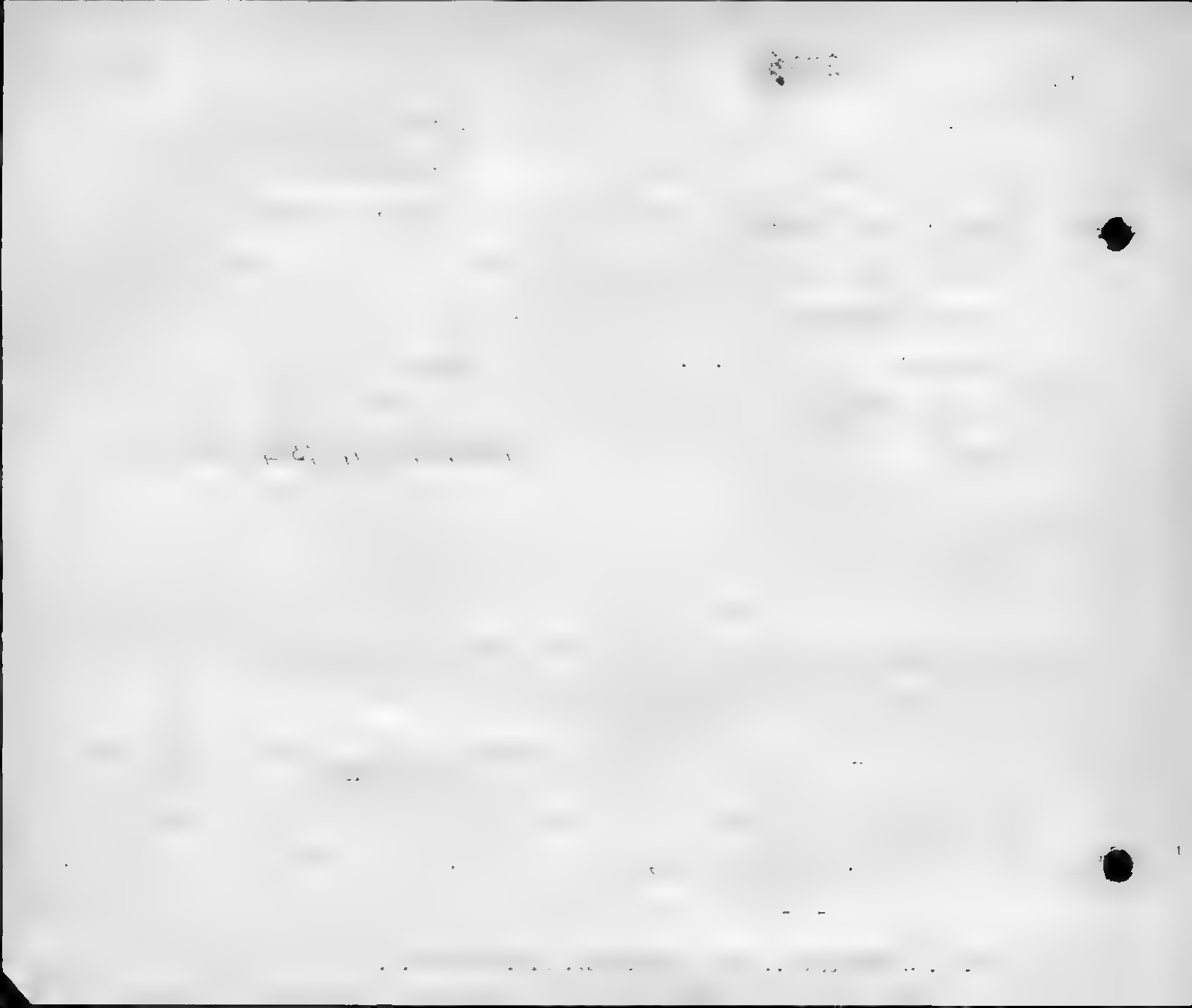
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3359

CERTIFICATE OF DEATH

03347

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY (in days) <b>25 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>5104 7th Street</b> d. STREET ADDRESS <b>5104 7th Street</b>		3. NAME OF DECEASED (Type or print) <b>David Griffith Schell</b> 4. DATE OF DEATH <b>March 26 1961</b> 5. SEX <b>Male</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11-20-07</b> 9. AGE (In years last birthday) <b>53 yrs</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Schell</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes</b> 16. SOCIAL SECURITY NO. <b>(W) 1015-1-11111</b> 17. INFORMANT <b>Lois Schell (W)</b> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adverse Circumstances</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Adverse Circumstances</b> 20c. TIME OF INJURY Month, Day, Year <b>March 1, 1961</b> Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U. S. Naval Hospital, Bethesda, Md.</b> 20f. (City or town) (County) (State) <b>U. S. Naval Hospital, Bethesda, Md.</b>		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 1, 1961</b> , to <b>March 26, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 26, 1961</b> , and that death occurred at <b>0353AM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>J. L. BEEBY LT, MC, USN</b> 22b. DATE SIGNED <b>3-26-61</b> 22c. PHYSICIAN'S NAME (Type) <b>J. L. BEEBY LT, MC, USN</b> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3-29-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., 1400 Chapin St., N.W. Wash. D.C.</b> 25a. REC'D BY REGISTRAR <b>MAR 28 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

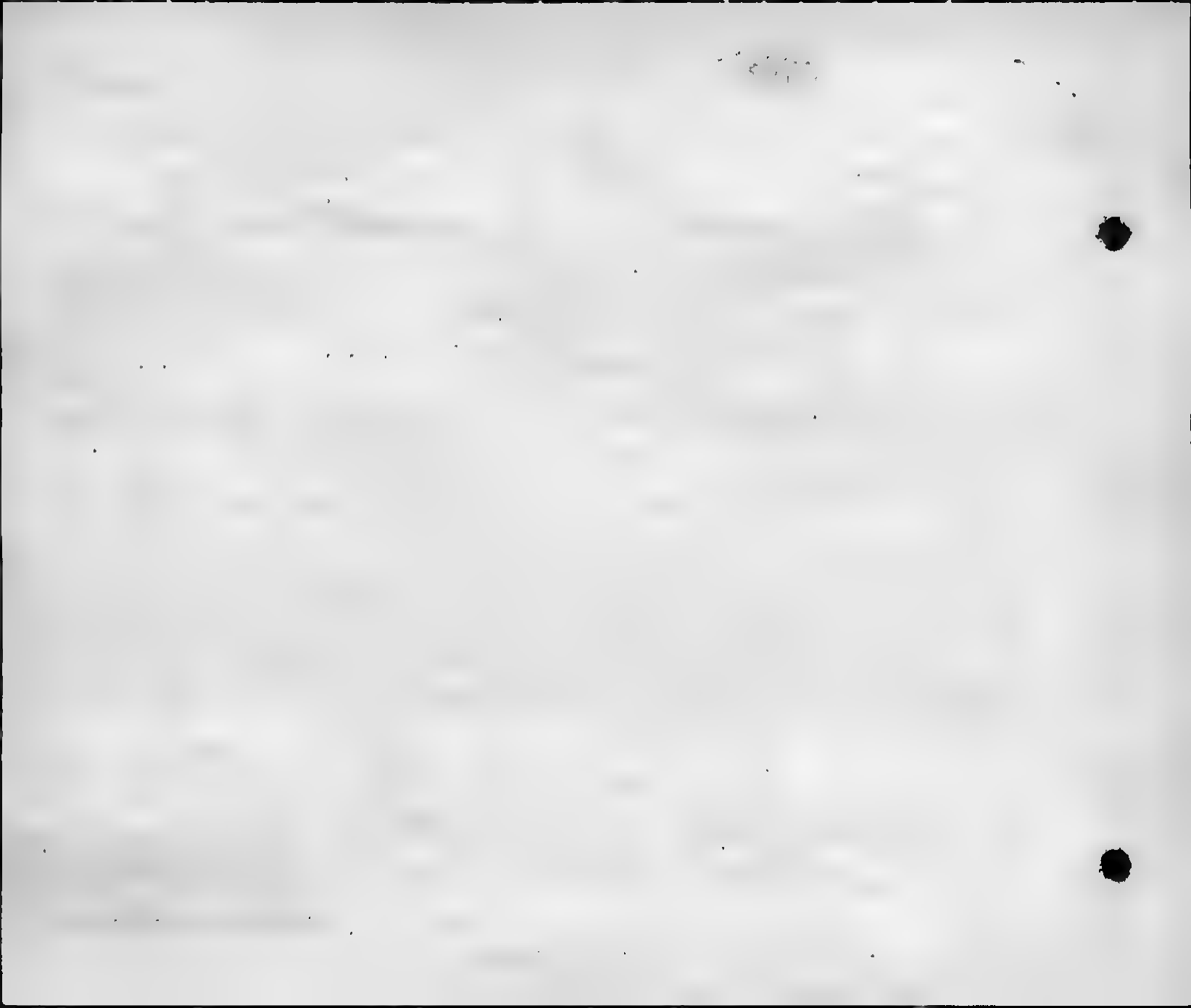
## 3360 CERTIFICATE OF DEATH

03349

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 1/2</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>DeRussey 4604 DeRussey Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Frederick W. Schneider</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Sales Manager</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>28</u> Year <u>1961</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>13. FATHER'S NAME</b> <u>John F. Schneider</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Imhof</u>		<b>15. INFORMANT</b> <u>Audrey Saxhaug (daughter)</u> Address <u>4868 Chevy Chase Blvd. Chevy Chase, Md.</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, severe</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis, generalised</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Essential Hypertension</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>3/27/61</u> Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from... 1958 to 3/28/61, that (I) (we) last saw the deceased alive on 3/27/61, and that death occurred at 9:00 AM, from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Stewart Clapp</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Stewart Clapp</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>4740 Ch. Ch. Dr. Chevy Chase Md.</u>		<b>22b. DATE SIGNED</b> <u>3-28-61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/31/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Prospect Hill Cemetery</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



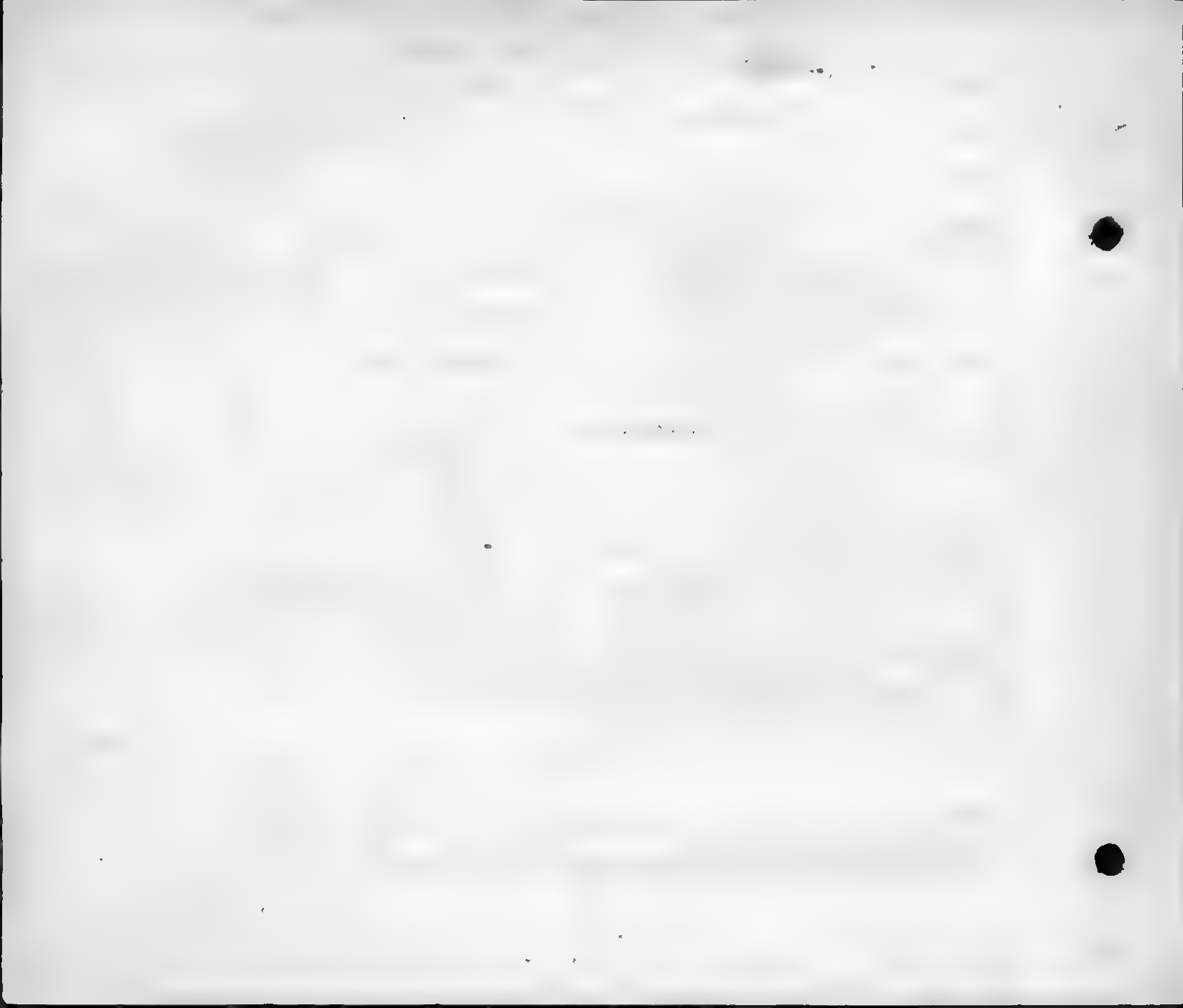
## CERTIFICATE OF DEATH

Reg. Dist. No. **03350****3361**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>38 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. STREET ADDRESS <u>1309 Dean Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Rose</u> Middle <u>Schottrodt</u> Last				4. DATE OF DEATH <u>March</u> Month <u>11</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Ainsworth</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-20-1318</u>		17. INFORMANT <u>Ruth Ashby</u>		Address <u>309 Dean Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Heart Disease</u> <u>4:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____		20g. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>November 1960</u> to <u>March 11, 1961</u> , that I last saw the deceased alive on <u>10 March 1961</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Veirs Mill Rd.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Herman Chaganzini</u> M.D.				PHYSICIAN'S NAME (Type) <u>Herman C. Chaganzini</u> <u>Rockville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 E. Montgomery Avenue</u> <u>Rockville, Md.</u>				24. REC'D BY REGISTRAR <u>Charles S. House</u> DATE <u>MAR 14 '61</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

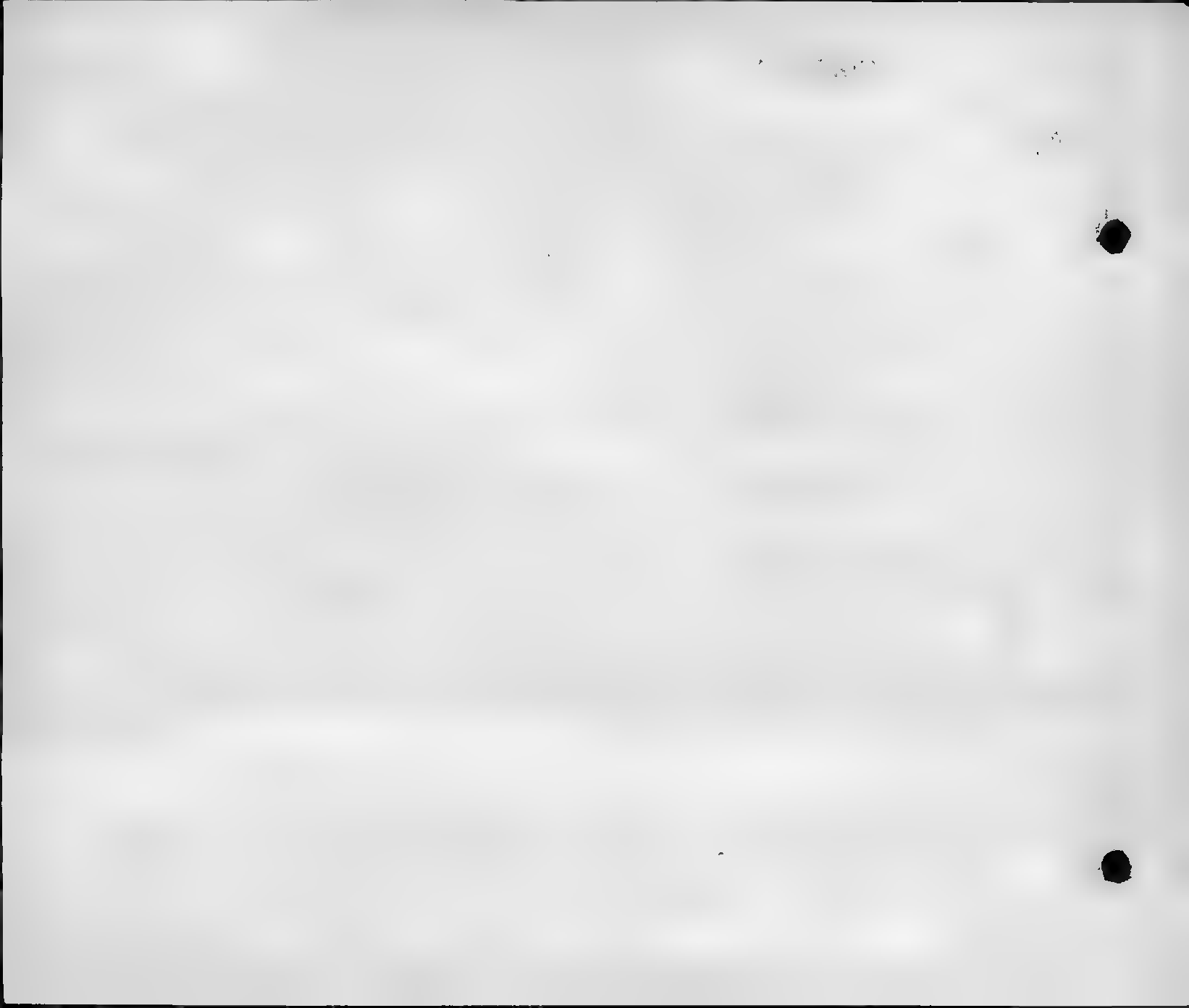
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03351

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN lb. <u>1 hr.</u>		d. STREET ADDRESS <u>12406 Parker Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) <u>10620 GEORGETOWN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irvin Robert Schreiber</u>		4. DATE OF DEATH <u>Mar 17 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-1914</u>
9. AGE (In years last birthday) <u>46 yrs</u>		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW HOMES</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>Morris E Schreiber (Dec)</u>		14. MOTHER'S MAIDEN NAME <u>Mary Black</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>518-03-2969</u>	
17. INFORMANT <u>Edith Schreiber - Sister</u>		Address <u>Stu</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Myocardial Infarction</u> DUE TO (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u> <u>unknown</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor from table in doctors office</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:24 a.m. 3-17 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschett</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschett</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Natl. Meow Park</u>		22d. LOCATION (City, town, or country) <u>Falls Church, Va.</u> (State) <u>VA</u>	
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		ADDRESS <u>4217-9th Ave</u>	
24a. REC'D BY REGISTRAR <u>Mar 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
M  
3363  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03352

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5124 Wessling Lane</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5124 Wessling Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William E. Schumann</b> First Middle Last 4. DATE OF DEATH <b>March 4 19 61</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>11/24/ 1876</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <b>84 yrs.</b> 10. IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> IF UNDER 24 HRS. Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Dentistry</b> 11. BIRTHPLACE (Country & State, or foreign country) <b>Missouri</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William E. Schumann</b> 14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Katharine G. Schumann-Wife-same 2d</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. <b>congestive heart failure</b> b. <b>arteriosclerotic heart disease</b> c. <b>generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e). INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>2/20, 1961, 10 3/4, 1961</b> Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>16 &amp; NW Wash 12 DC</b> 20f. (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md.</b>		21. I certify that (I) (this hospital) attended the deceased from <b>2/20, 1961, to 3/4, 1961</b> , that (I) <b>(me)</b> last saw the deceased alive on <b>3/4, 1961</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above 22a. SIGNATURE <b>H. F. Kreuzburg</b> 22c. PHYSICIAN'S NAME (Type) <b>H. F. Kreuzburg</b> 22d. ADDRESS <b>7852 16 &amp; NW Wash 12 DC</b> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED <b>3/5/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/7/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b> 23d. LOCATION (City, town or county) <b>Silver Spring, Md.</b> (State) <b>Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b> 25a. REC'D BY REGISTRAR <b>MAR 8 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

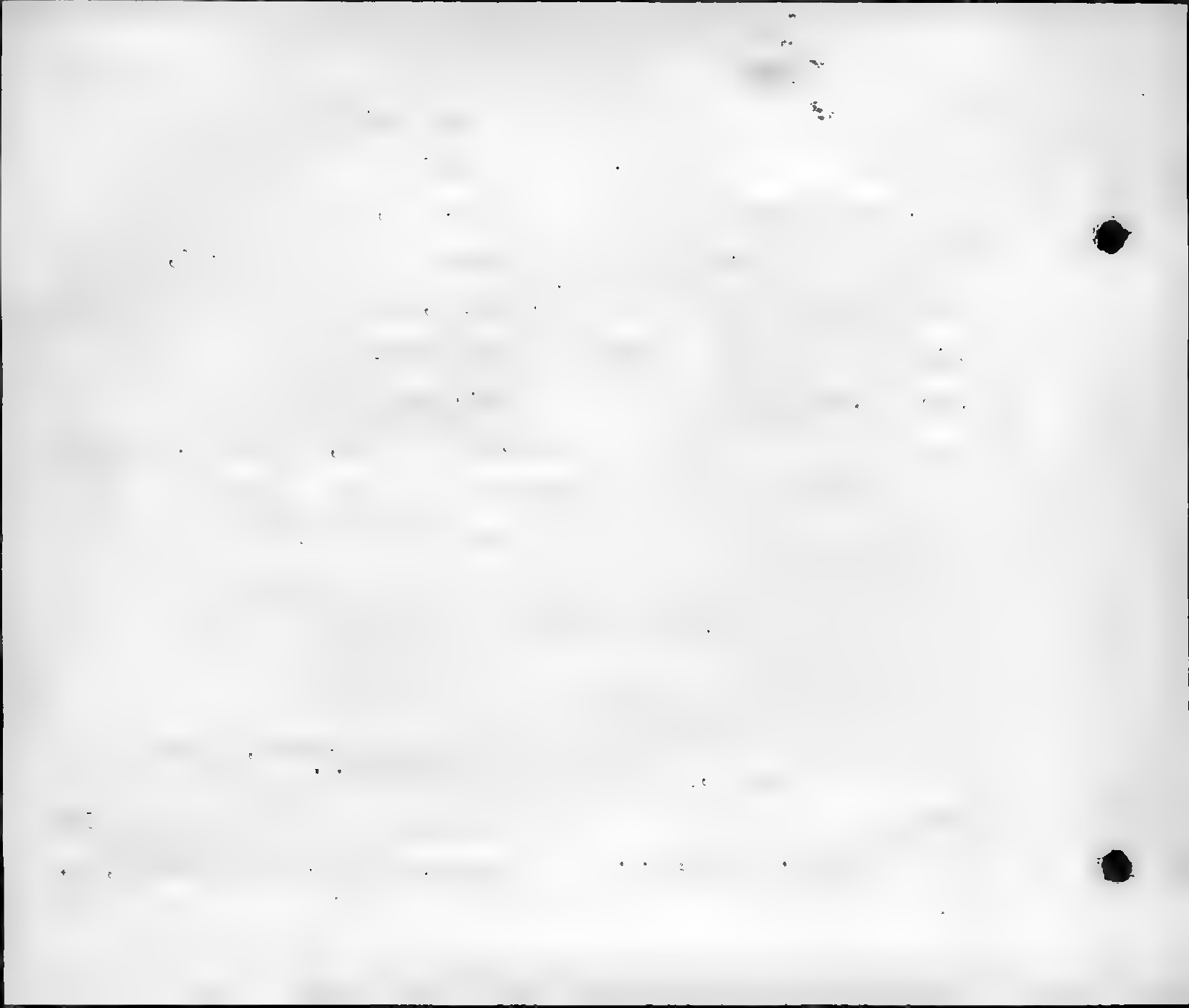
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3368

CERTIFICATE OF DEATH

03356

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>23 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Clendenin</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>85 3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>Route #4, Box 127</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patty Lyn Seabolt</b>		4. DATE OF DEATH Month Day Year <b>March 3, 19 61</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 8, 1958</b>		9. AGE (In years lost birthday) <b>3 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Charlie R. Seabolt</b>		14. MOTHER'S MAIDEN NAME <b>Wavie King</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>54.3</b> DUE TO <b>arteriosclerosis + congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ly anotic Congenital heart disease</b> DUE TO <b>Since birth</b> (c) <b>Cardiac Surgery</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Surgery</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>February 8, 1961</b> , to <b>March 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1961</b> , and that death occurred at <b>11:18 a.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>James L. Talbert</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/3/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>JAMES L. TALBERT, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIR RR</b>		23b. DATE THEREOF <b>3-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REED'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HAMMA WEST, VA.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		ADDRESS <b>1400 Chapin St. N.E.</b>		25a. REC'D BY REGISTRAR <b>MAR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krand</b>					



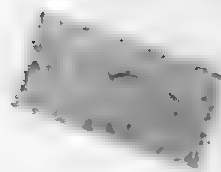
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3364

03357

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Rest Home</b>				d. STREET ADDRESS <b>14702 Essex Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth C Searles</b>				4. DATE OF DEATH Month Day Year <b>March 31 19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1868</b>		9. AGE (In years last birthday) <b>92 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Peter F. Causey</b>				14. MOTHER'S MAIDEN NAME <b>Jane E. Dickinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Dale C. Morgan-daughter-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>ARTERIOSCLEKOSIS GENERAL</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 HRS.</b> <b>5 Mo.</b> <b>4 YRS.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 19 58</b> to <b>MARCH 30 1961</b> , that (I) (we) last saw the deceased alive on <b>MARCH 30 1961</b> , and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Leo M. Curtis</b>		M.D. <b>Leo M. Curtis, M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3-31-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leo M. Curtis, M.D.</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 3 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

3369 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03358

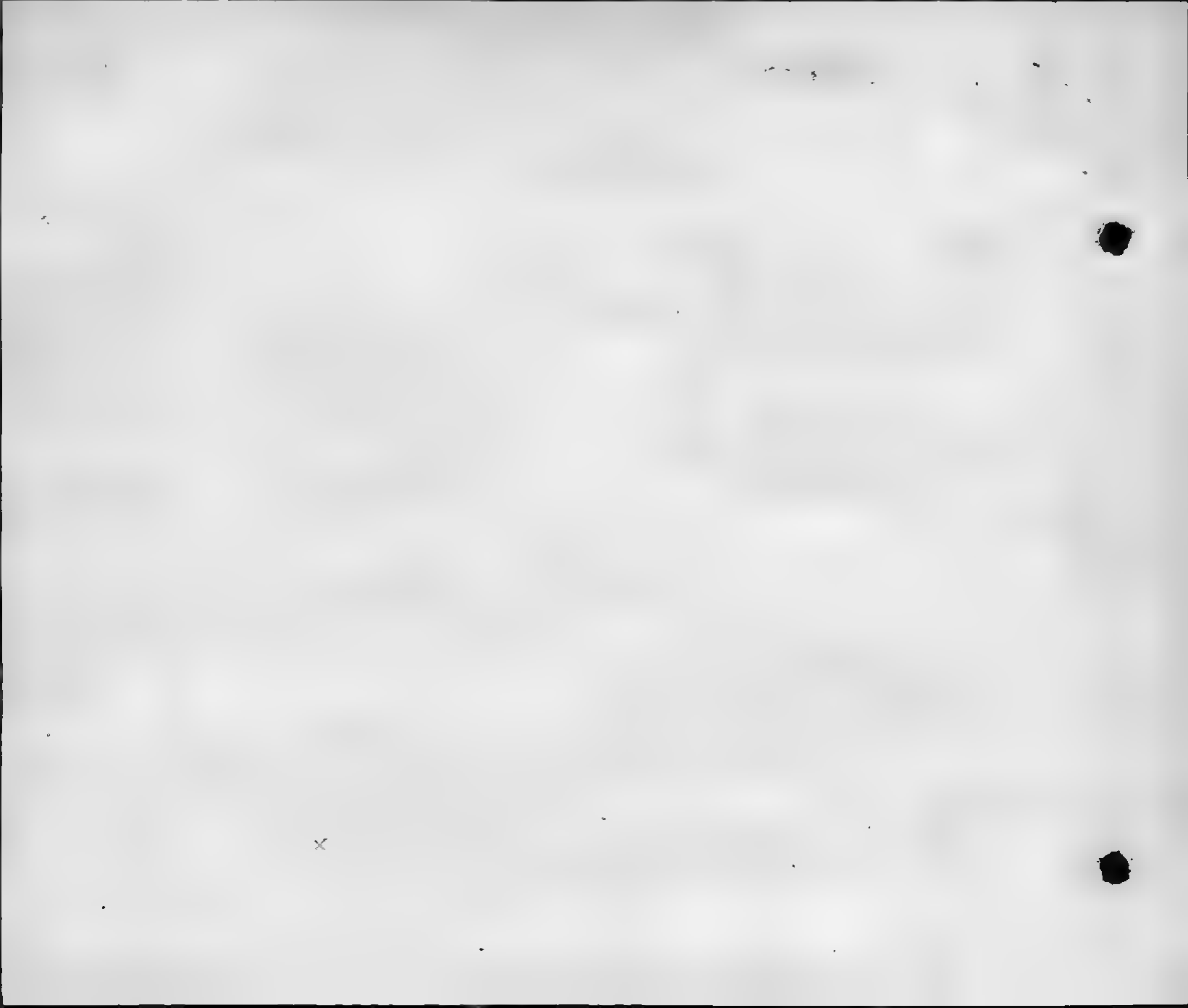
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		d. STREET ADDRESS 23 Walker Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles		4. DATE OF DEATH March 9 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/66		9. AGE (in years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorenal failure DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Open reduction fracture rt. hip DUE TO (c) Fall in his yard PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced arteriosclerosis general 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Was walking in back yard, fell fracturing right hip		20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 3/3 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Gaithersburg	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 3-10-61		22c. NAME OF CEMETERY OR CREMATORY West Laurel Hill Cem.		22d. LOCATION (City, town, or country) Philadelphia, Penna.		23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DATE MAR 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kears			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE *Frank J. Broschart*  
EXAMINER'S NAME (Type) Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED  
3/10/61



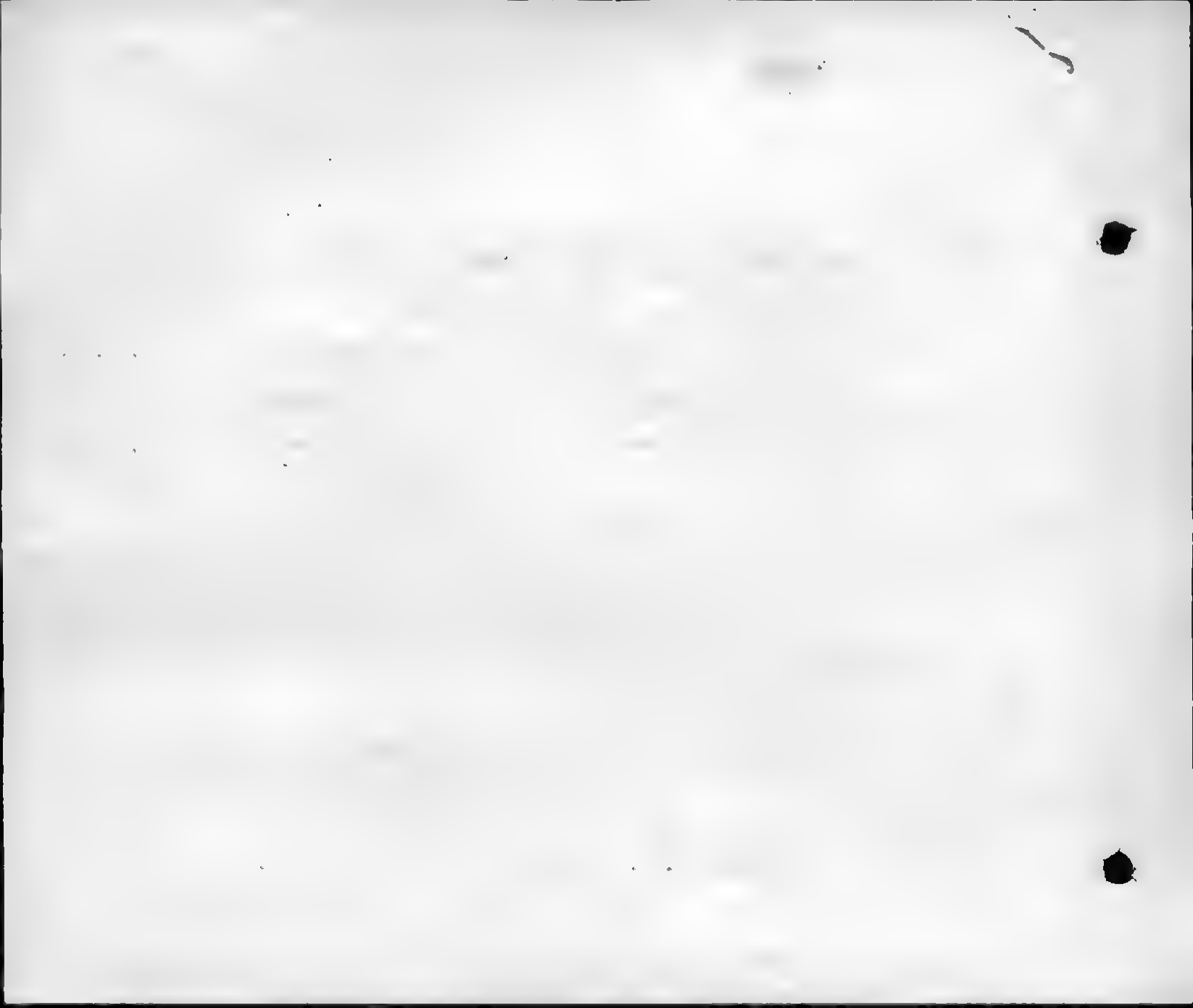
may be obtained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03359

3370

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>46 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>			
				d. STREET ADDRESS <b>103 SUMMIT AVE.</b>			
3. NAME OF (Type or print) First Middle Last <b>John Robert Shippe</b>				4. DATE OF DEATH Month Day Year <b>MARCH 20 19 61</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/1889</b>		9. AGE (In years last birthday) <b>71</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES EDWARD SHIPE</b>				14. MOTHER'S MAIDEN NAME <b>LUCY LEE CUNNINGHAM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-16-1627</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pancreatitis Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 1, 1961</b> to <b>3-20, 1961</b> that (I) (we) lost saw the deceased alive on <b>3-19-1961</b> and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Jack Schumacher</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>				22d. ADDRESS <b>GAITHERSBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 23 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





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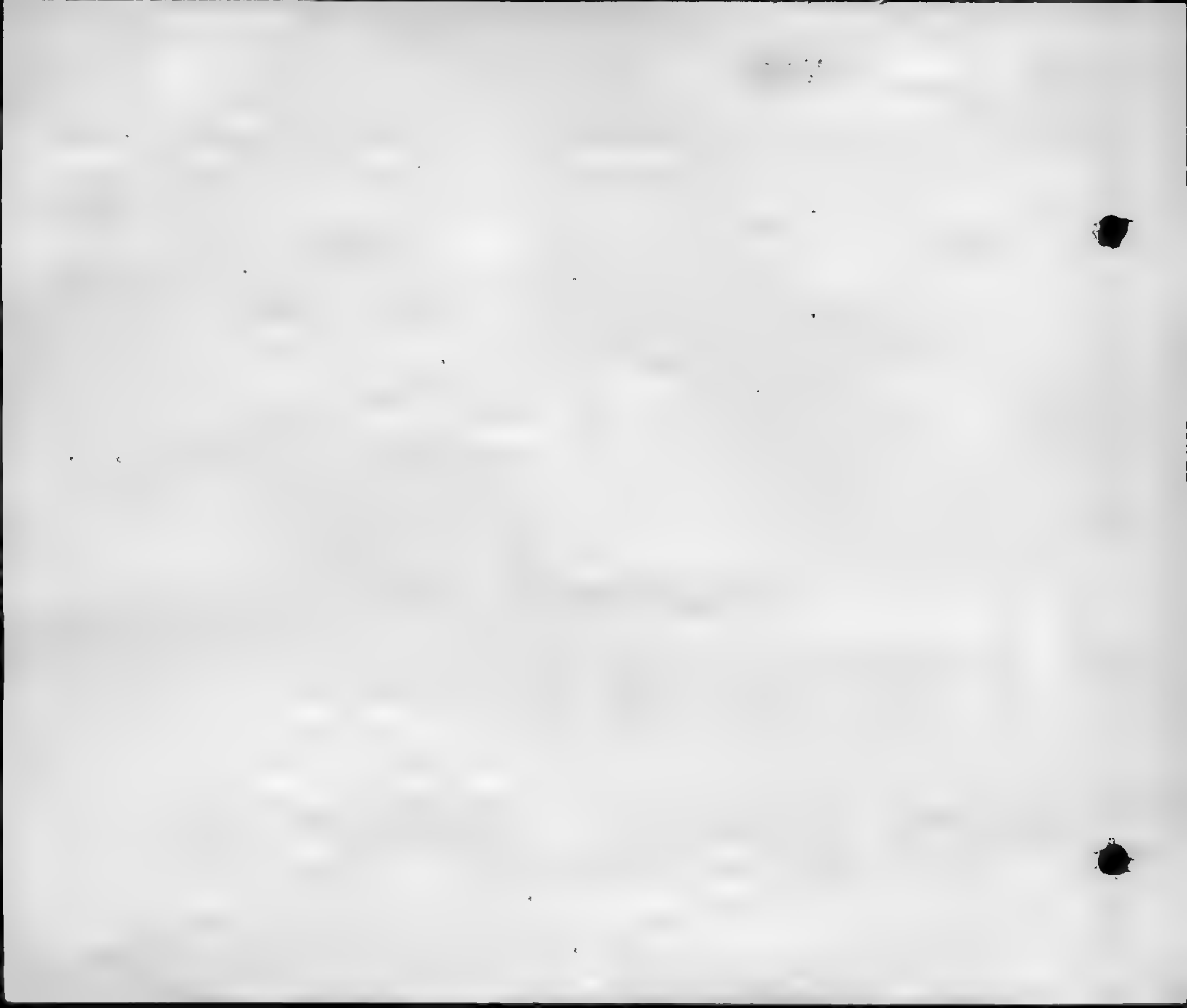
TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3363  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03353

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> c. LENGTH OF STAY IN b <u>10 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lone Pine Inn</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u> d. STREET ADDRESS <u>RFD # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Norman Shirley</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>20</u> Year <u>1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 7 1914</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Shirley</u>		14. MOTHER'S MAIDEN NAME <u>Cora Johnson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Wellington Shirley RFD 3 Gaithersburg, Md.</u>		Address <u>  </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anterior myocardial infarction</u> <u>420.1</u> DUE TO (b) <u>Obstruction, Anterior descending coronary artery branch</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Coronary Arteriosclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Unknown</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u>		(County) <u>  </u>		(State) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Mar. 20, 1961</u>	
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>		22a. BURIAL, CREMATION, REMOVAL (Set by) <u>Burial</u>		22b. DATE THEREOF <u>3/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove.</u>		22d. LOCATION (City, town, or country) <u>Gaithersburg, Md.</u>		(State) <u>  </u>		23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REG STRAR DATE <u>MAR 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

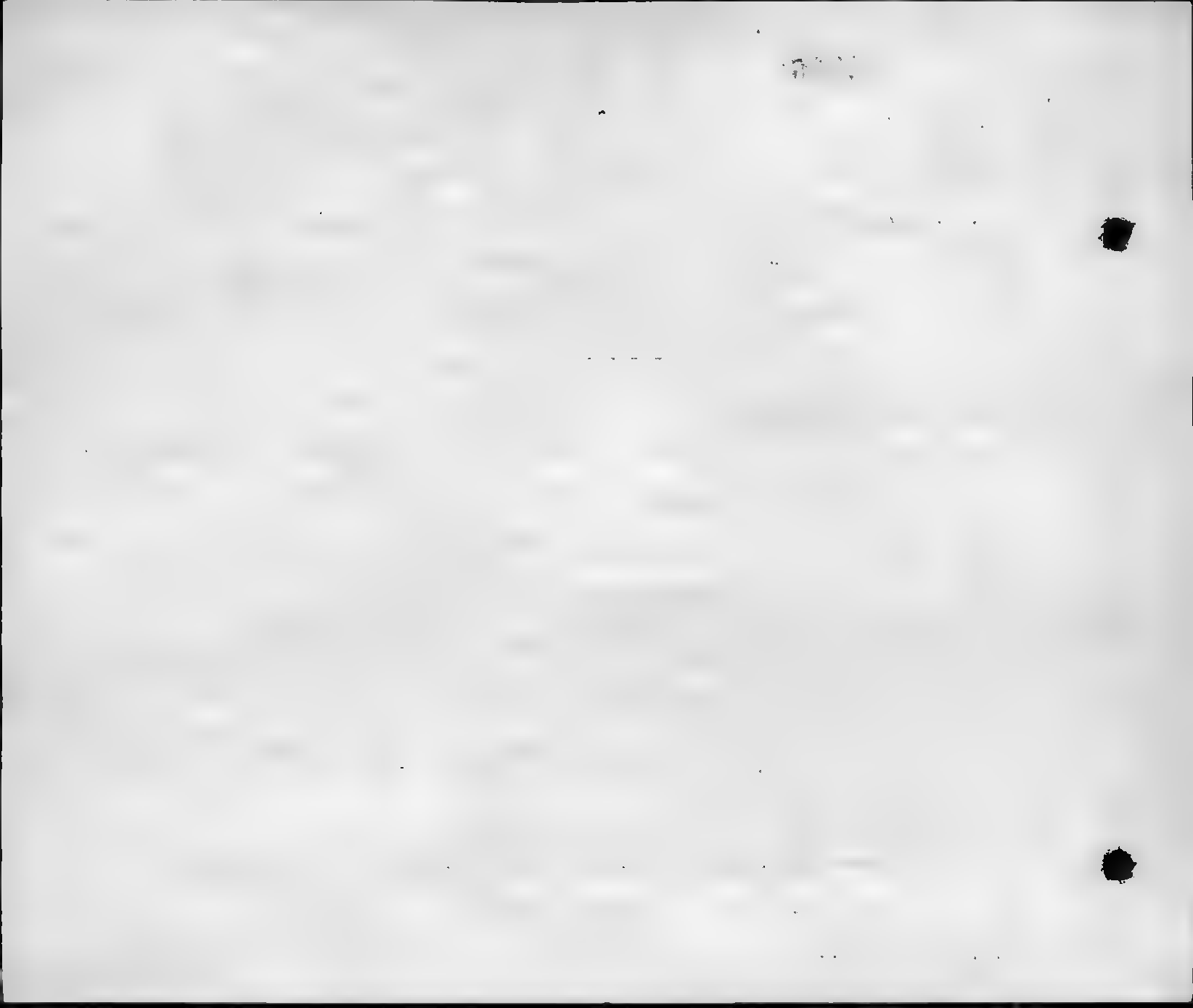


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3366 CERTIFICATE OF DEATH

03354

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE Ohio	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenville	
c. LENGTH OF STAY IN b. 10 days		d. STREET ADDRESS 401 Memorial Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			
<b>3. NAME OF DECEASED</b> (Type or print) Mark		<b>4. DATE OF DEATH</b> March 17 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-24-61	
9. AGE (In years last birthday) 1 yr. 21 mos. 21 days		10. AGE (In years last birthday) 1 yr. 21 mos. 21 days	
11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
<b>13. FATHER'S NAME</b> David Kent SHIVERDECKER		<b>14. MOTHER'S M.A.DEN NAME</b> Marcia E. GAMBANCORTA	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> None	
<b>17. INFORMANT</b> (F) David K. Shiverdecker, same as #2 above		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septaemia DUE TO (b) Pylonephritis DUE TO (c) Hydronephrosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) (1) Malnutrition (2) Absent, congenital, Rt. Kidney		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from March 7, 1961, to March 17, 1961, that (b) (we) last saw the deceased alive on March 17, 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Lawrence G. Thorne M.D.		22b. DATE SIGNED 3-17-61	
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-18-61	
23c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery		23d. LOCATION (City, town or county) (State) Greenville Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 3072 M St., NW, WashDC		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



3367

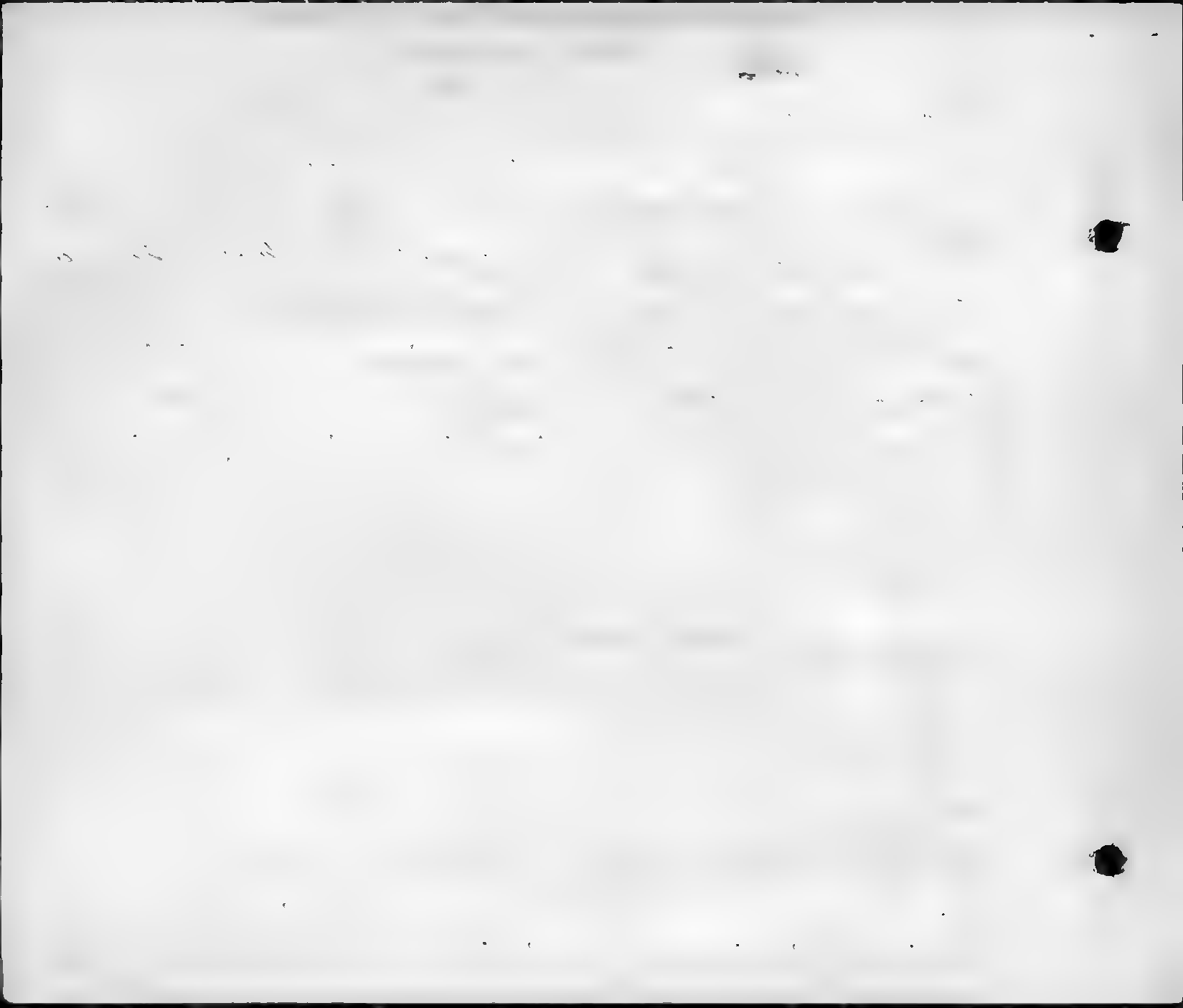
## CERTIFICATE OF DEATH

Reg. Dist. No. 03355

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>3700 Dupont Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <b>CARRIE</b> Middle <b>BELLE</b> Last <b>SHROAT</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/21/79</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRESSMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>ATLANTA, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEMUEL BRIGMAN</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE GILLIAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Jack W. Harville, 3700 Dupont Ave. Kensington, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> <b>32X</b> DUE TO (b) <b>Phlebotrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Generalized arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bladder tumor removed 7/60</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/13, 1961</b> , to <b>Mar 23, 1961</b> , that I last saw the deceased alive on <b>Mar 23, 1961</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>88015 Conn. Ave. Chevy Chase 15 MD</b> DATE SIGNED <b>5/26/61</b>			
ACTUAL SIGNATURE <b>John B. Umhau</b> M.D.		PHYSICIAN'S NAME (Type) <b>John B. Umhau</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/29/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>RIVERSIDE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ASHEVILLE, NORTH CAROLINA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Biska</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Walter E. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



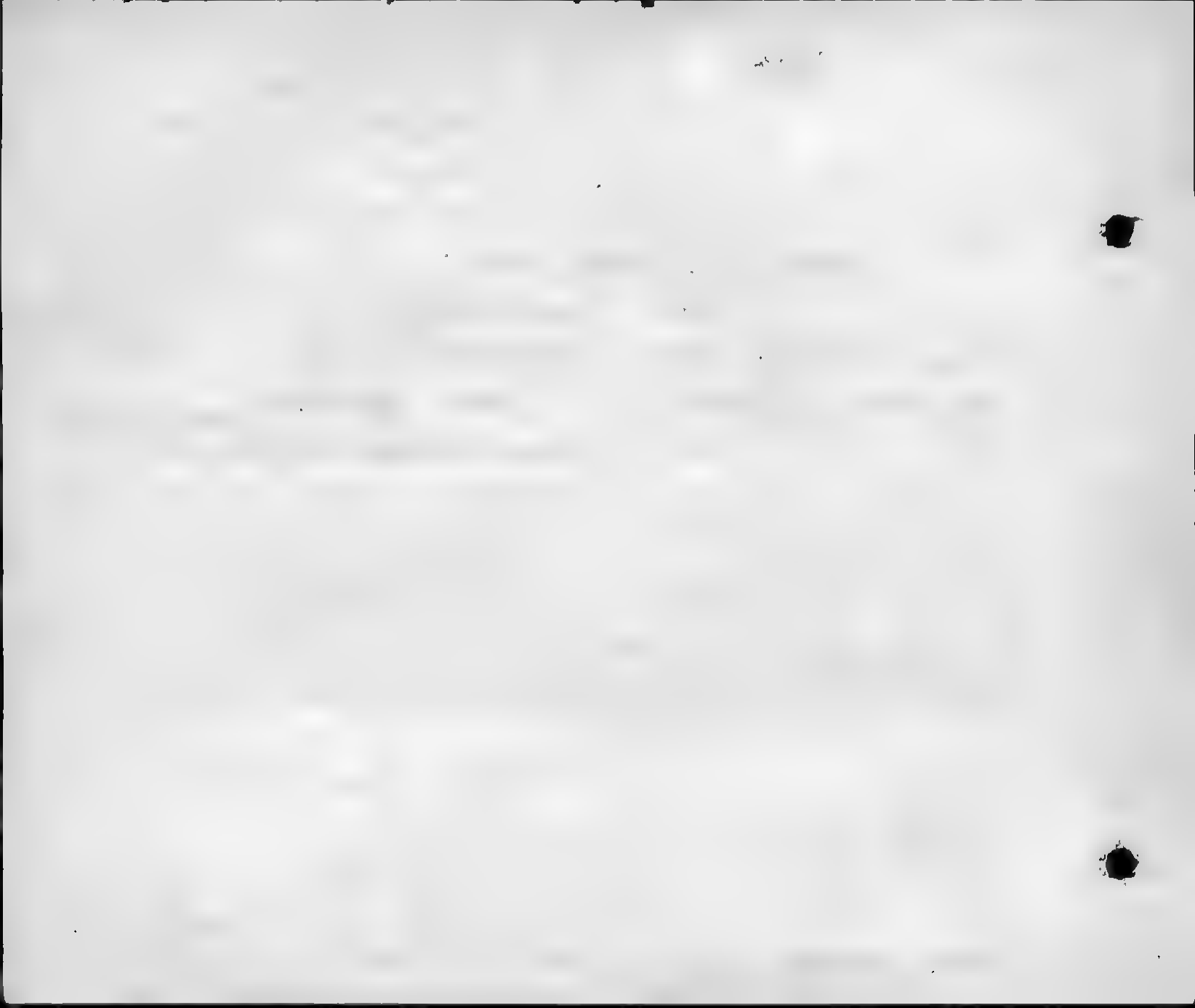
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. The law requires that the death certificate be signed by the attending physician and completed by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3371 CERTIFICATE OF DEATH 03360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maine</u> <u>Penobscot</u> COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dexter</u> c. STREET ADDRESS <u>255 Main St.</u> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Louie Smart</u> First Middle Last 4. DATE OF DEATH <u>March 28, 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 22, 1888</u> 9. AGE (In years last birthday) <u>72</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Supervisor</u> 12b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u> 12c. FATHER'S NAME <u>William Cowie</u> 12d. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No.</u> 14. SOCIAL SECURITY NO. <u>005-38-6429</u> 15. INFORMANT <u>Martin Henderson, 5913 Cheshire</u> Address <u>Bethesda, Md.</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Uremia</u> 153 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Obstruction, Partial</u> 5 days (c) <u>Carcinoma of Colon</u> 10 months		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive Carcinomatosis</u> 17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20b. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1961</u> to <u>March 1961</u> , that (I) (we) last saw the deceased alive on <u>3-28-1961</u> , and that death occurred at <u>8:50 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James W. Long, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES W. LONG</u>		22b. DATE SIGNED <u>3-28-61</u> 22d. ADDRESS <u>6601 - Frontenac Rd. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Dexter, Maine</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chuan Fung</u> ADDRESS <u>5103 Vin Ave Wash DC</u>		25a. REC'D BY REGISTRAR <u>APR 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

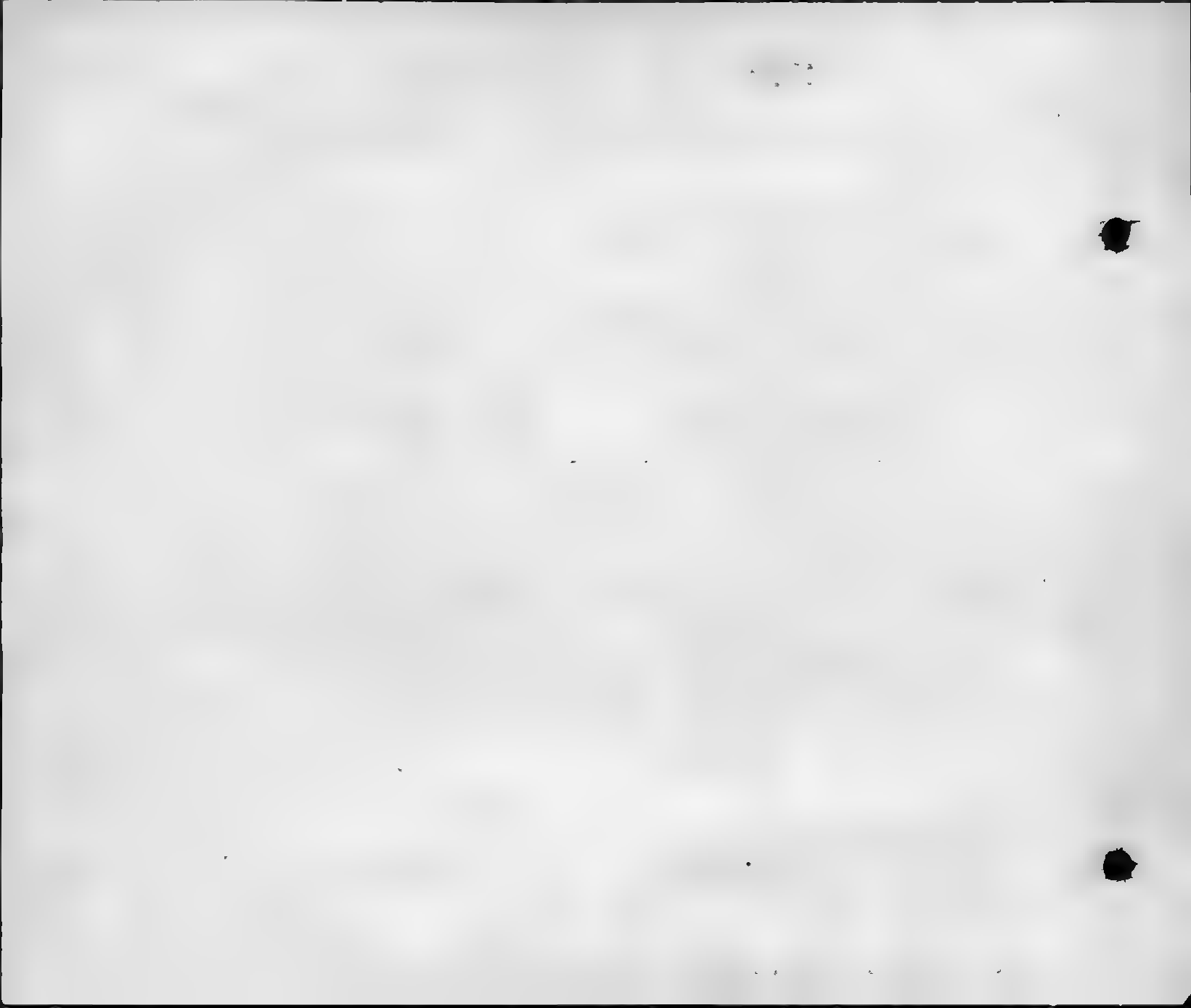
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3372

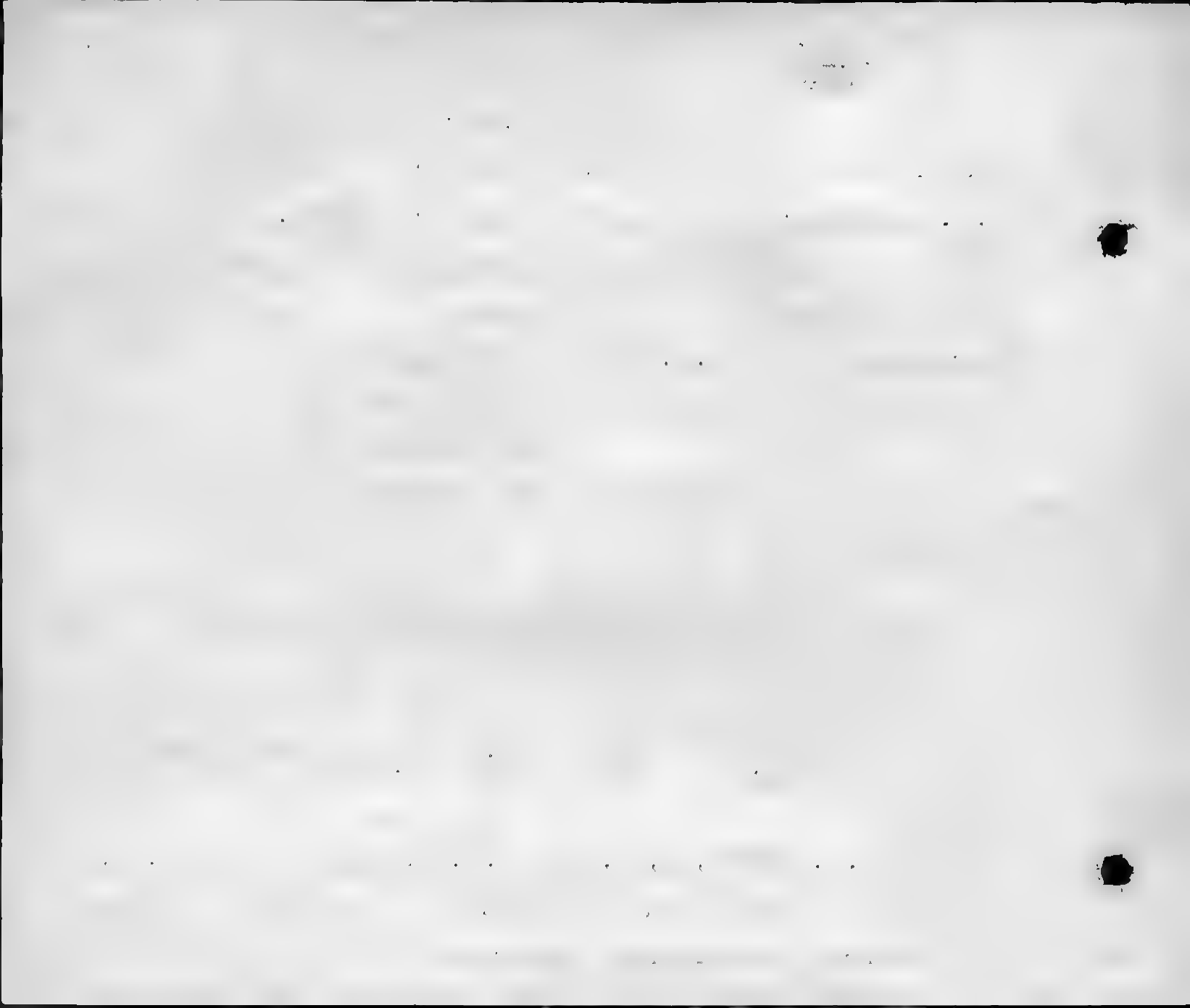
CERTIFICATE OF DEATH

03361

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>6 1/2</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>10130 Cedar Lane</u>		<b>3. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>															
<b>1. NAME OF DECEASED</b> (Type or print) <u>Cleveland C. Smith</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>12</u> Year <u>1961</u>		<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-8-82</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>12</u> Hours <u>19</u> Min. <u>61</u>		<b>IF UNDER 24 HRS.</b> Months <u>1</u> Days <u>12</u> Hours <u>19</u> Min. <u>61</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; P. R.R. Trackman</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Tennessee</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Yes</u>		<b>13. FATHER'S NAME</b> <u>Charles Smith</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Fresca Trail</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>705-097642</u>		<b>17. INFORMANT</b> <u>Jim Smith</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Central Vascular accident</u> (c) <u>underlying</u> cause last.	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Central Vascular accident</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-5</u> <b>1961, to</b> <u>3-12</u> <b>1961, that (I) (we) last saw the deceased alive on</b> <u>3-11</u> <b>1961, and that death occurred at</b> <u>11:55 AM</u> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Sarah E. Glover</u>		<b>22b. DATE SIGNED</b> <u>3-15-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Sarah E. Glover</u>		<b>22d. ADDRESS</b> <u>10128 CEDAR LANE KENSINGTON, MD.</u>		<b>22e. REC'D BY REGISTRAR</b> <u>W.B. Hilton</u>		<b>22f. REGISTRAR'S SIGNATURE</b> <u>Barneville</u>		<b>22g. DATE</b> <u>MAR 16 '61</u>		<b>22h. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Monocacy</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Beallville, Md.</u>		<b>23e. REGISTRAR'S SIGNATURE</b> <u>W.B. Hilton</u>		<b>23f. DATE</b> <u>MAR 16 '61</u>		<b>23g. REGISTRAR'S SIGNATURE</b> <u>Barneville</u>		<b>23h. DATE</b> <u>MAR 16 '61</u>		<b>23i. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			







TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

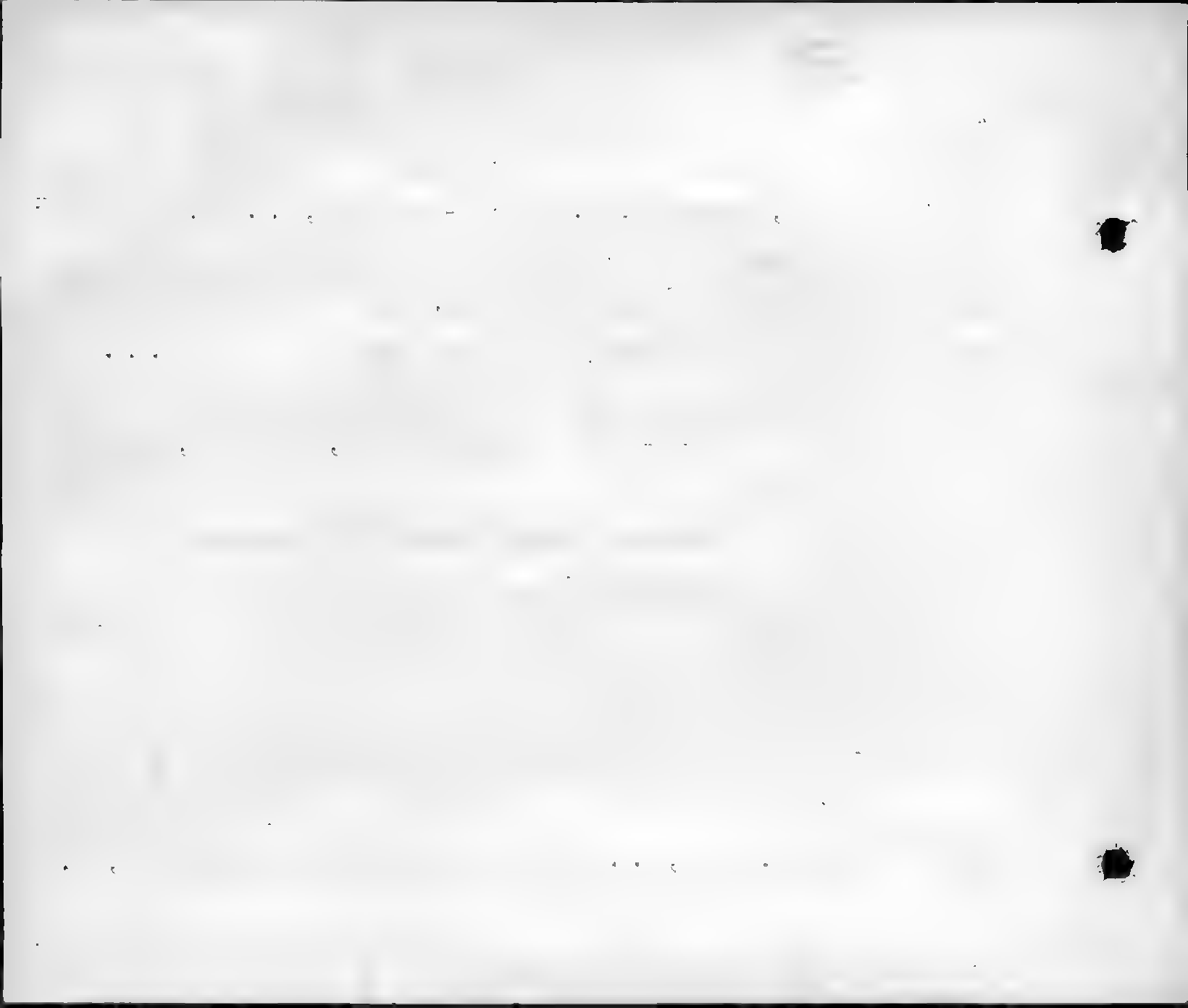
<div>Item 28 Film 284 4-6-21</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> <div>3374</div> <div>CERTIFICATE OF DEATH</div> <div>03363</div>													
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>10 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>						d. STREET ADDRESS <b>1631 - 6th Street, N.W. Apt. #12</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>(None)</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1961</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>June 17, 1904</b>			9. AGE (In years last birthday) <b>56</b> yrs			10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>		11. IF UNDER 24 HRS Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>				11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Padgett</b>						14. MOTHER'S MAIDEN NAME <b>Lizzie Burtons</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>197-18-6985</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ureteral Bilateral lateral obstruction &amp; Pyelonephritis</b> DUE TO (c) <b>Carcinoma of the Cervix</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 days</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) [County] (State)				20g. (City or town) [County] (State)									
21. I certify that (he/she/this hospital) attended the deceased from <b>March 17, 1961</b> to <b>March 27, 1961</b> that (we) last saw the deceased alive on <b>March 27, 1961</b> , and that death occurred at <b>5:30 PM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Donald L. Morton</b> M.D.				22b. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				22c. DATE SIGNED <b>3/27/61</b>					
23a. BURIAL OR CREMATION REMOVAL (Specify) <b>3-31-61</b>				23b. DATE THEREOF <b>3-31-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat.</b>					
23d. LOCATION (City, town, or county) <b>Washington</b>				23e. (State) <b>D.C.</b>				23f. (City, town, or county) <b>Washington</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.S. Washington Sons</b>				25a. REC'D BY REGISTRAR DATE <b>3 01</b>				25b. REGISTRAR'S SIGNATURE <b>William E. Frank</b>					

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MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3375

## CERTIFICATE OF DEATH

03364

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>82 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Zanesville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2630 Dresden Rd. c/o Sharp</u> d. STREET ADDRESS <u>2630 Dresden Rd. c/o Sharp</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>First Middle Last</u> <u>Roland Diehl SMITH</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Finance</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ICA, State Dept.</u> <b>11. BIRTHPLACE</b> (Country and State or foreign country) <u>Ohio</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>14</u> Year <u>1961</u> <b>9. AGE</b> (In years IF UNDER 1 YEAR; IF UNDER 24 HRS last birthday) Months <u>60</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u> <b>13. FATHER'S NAME</b> <u>Harry C. SMITH</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie D. DIEHL</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes WWII</u> <b>16. SOCIAL SECURITY NO.</b> <u>274-16-0445</u> <b>17. INFORMANT</b> <u>(W) Mrs. Avis M. Smith, same as #2 above</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRACHEAL OBSTRUCTION</u> DUE TO (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) <u>MYASTHENIA GRAVIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>Dec. 22 1960</u> Hour a.m. <u>9:15AM</u> p.m. <u>0</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, Bethesda, Md.</u> <b>20f. (City or town)</b> <u>Arlington</u> <b>20g. (County)</b> <u>Virginia</u> <b>20h. (State)</b> <u>Virginia</u> <b>21. I certify that</b> (this hospital) attended the deceased from <u>Dec. 22 1960</u> to <u>March 14 1961</u> that (s) (we) last saw the deceased alive on <u>March 14 1961</u> , and that death occurred at <u>9:15AM</u> M, from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>W. L. DeBolt</u> <b>22b. DATE SIGNED</b> <u>3-14-61</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. L. DEBOLT, LT, MC, USN</u> <b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u> <b>23b. DATE THEREOF</b> <u>3-17-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u> <b>23d. LOCATION (City, town or county)</b> <u>Arlington</u> <b>23e. (State)</b> <u>Virginia</u> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. A. Pumphrey</u> <b>25a. REC'D BY REGISTRAR</b> <u>MAR 15 1961</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kinn</u> <b>25c. DATE</b> <u>MAR 15 1961</u>	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

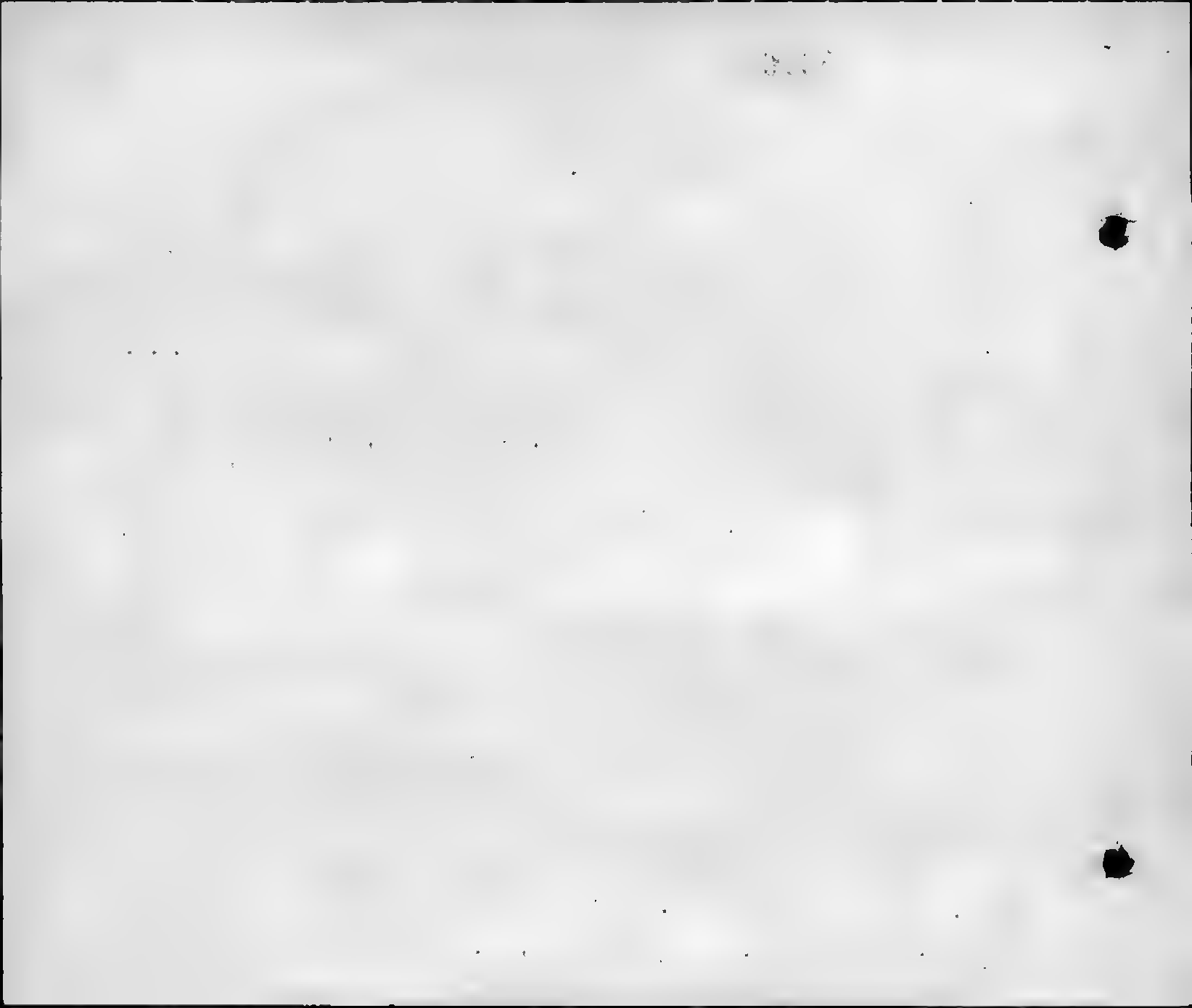
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3376

## CERTIFICATE OF DEATH

03365

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY IN b. <b>3 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4509 WOODLARK PLACE</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Res. since before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> d. STREET ADDRESS <b>4509 WOODLARK PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ANNA</b> First Middle Last <b>SPIZUOCO</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>7</b> Year <b>1961</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/7/88</b>
<b>9. AGE</b> (In years last birthday) <b>72</b> yrs		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>	
<b>11. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>FREDERICK GOTTACHAUCK</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	
<b>17. INFORMANT</b> <b>Mrs. Jean Walters, 4509 Woodlark Place Rockville, Maryland</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Diabetes Mellitus</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 1, 1959</b> <b>to</b> <b>March 7, 1961</b> , that (I) <b>(the)</b> <b>last</b> saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>S. L. TABB, M.D.</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>S. L. TABB, M.D.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>TRANS. &amp; BURIAL 3/11/61</b>		<b>23b. DATE THEREOF</b> <b>3/11/61</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>WALTER E. PUMPHREY, INC.</b> <b>Raymond A. J. J. J.</b>		<b>25. RECORD BY REGISTRAR</b> <b>MAR 10 61</b>	
<b>26. REGISTRAR'S SIGNATURE</b> <b>Charles S. Thomas</b>		<b>27. ADDRESS</b> <b>SILVER SPRING, MD.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3377

CERTIFICATE OF DEATH

03366

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>39 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>3303 Oberon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mildred Jacquelyn Summers</b>			4. DATE OF DEATH <b>March 3, 1961</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1911</b>		9. AGE (In years lost birthday) <b>49</b> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>			
13. FATHER'S NAME <b>John Griffith</b>			14. MOTHER'S MAIDEN NAME <b>Ada V. Cross</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>Unascertainable</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>110A</b> DUE TO <b>Inflow obstruction</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of breast</b> (c) <b>Years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>Months</b> <b>Years</b>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>January 23, 1961</b> to <b>March 3, 1961</b> that (I) (we) last saw the deceased alive on <b>March 3, 1961</b> and that death occurred at <b>4:55 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Benjamin J. Borowsky</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>3/4/61</b>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Benjamin J. Borowsky M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes Of Health, Bethesda 14, Maryland</b>					
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			
				23d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3378

03367

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>MONTGOMERY</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p> <p>c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)</p> <p>a. STATE <u>MARYLAND</u></p> <p>b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u></p> <p>d. STREET ADDRESS <u>11 Woodmoor Drive</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Waiter Henry</u></p> <p>5. SEX <u>Male</u></p> <p>6. COLOR OR RACE <u>White</u></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>2-9-03</u></p> <p>9. AGE (In years if under 1 year, last birthday) <u>58</u> yrs. Months <u>3</u> Days <u>25</u> Hours <u>1</u> Min <u>1</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Iowa</u></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>USA</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>13. FATHER'S NAME <u>Samuel L. Swartz</u></p> <p>14. MOTHER'S MAIDEN NAME <u>Bertha Schwartz</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p> <p>16. SOCIAL SECURITY NO. <u>10</u></p> <p>17. INFORMANT <u>Hospital Records</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebellar hemorrhage</u></p> <p>IX DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a. _____</p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>12-d</u></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____</p>			
<p>20c. TIME OF INJURY Month, Day, Year <u>19</u></p> <p>Hour a.m. _____ p.m. _____</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____</p> <p>20f. (City or town) _____ (County) _____ (State) _____</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>March 25, 1961</u>, that (I) (we) last saw the deceased alive on <u>March 24, 1961</u>, and that death occurred at <u>1:04 P.M.</u> from the causes and on the date stated above</p>			
<p>22a. SIGNATURE <u>Abraham W. Danish</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u></p>		<p>22b. DATE SIGNED <u>3-25-61</u></p> <p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p> <p>22d. ADDRESS <u>622 BERTHOLD DR - SILVER SPRING</u></p>	
<p>23a. BURIAL, CREMATION <u>Burial</u></p> <p>23b. DATE THEREOF <u>March 28, 1961</u></p>		<p>23c. NAME OF SEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u></p> <p>23d. LOCATION (City, town or county) <u>Prince Geo. Co. Md.</u></p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Wallis</u></p> <p>24b. ADDRESS <u>254 Carroll Hill NW D.C.</u></p>		<p>25a. REC'D BY REGISTRAR <u>MAR 28 '61</u></p> <p>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u></p>	

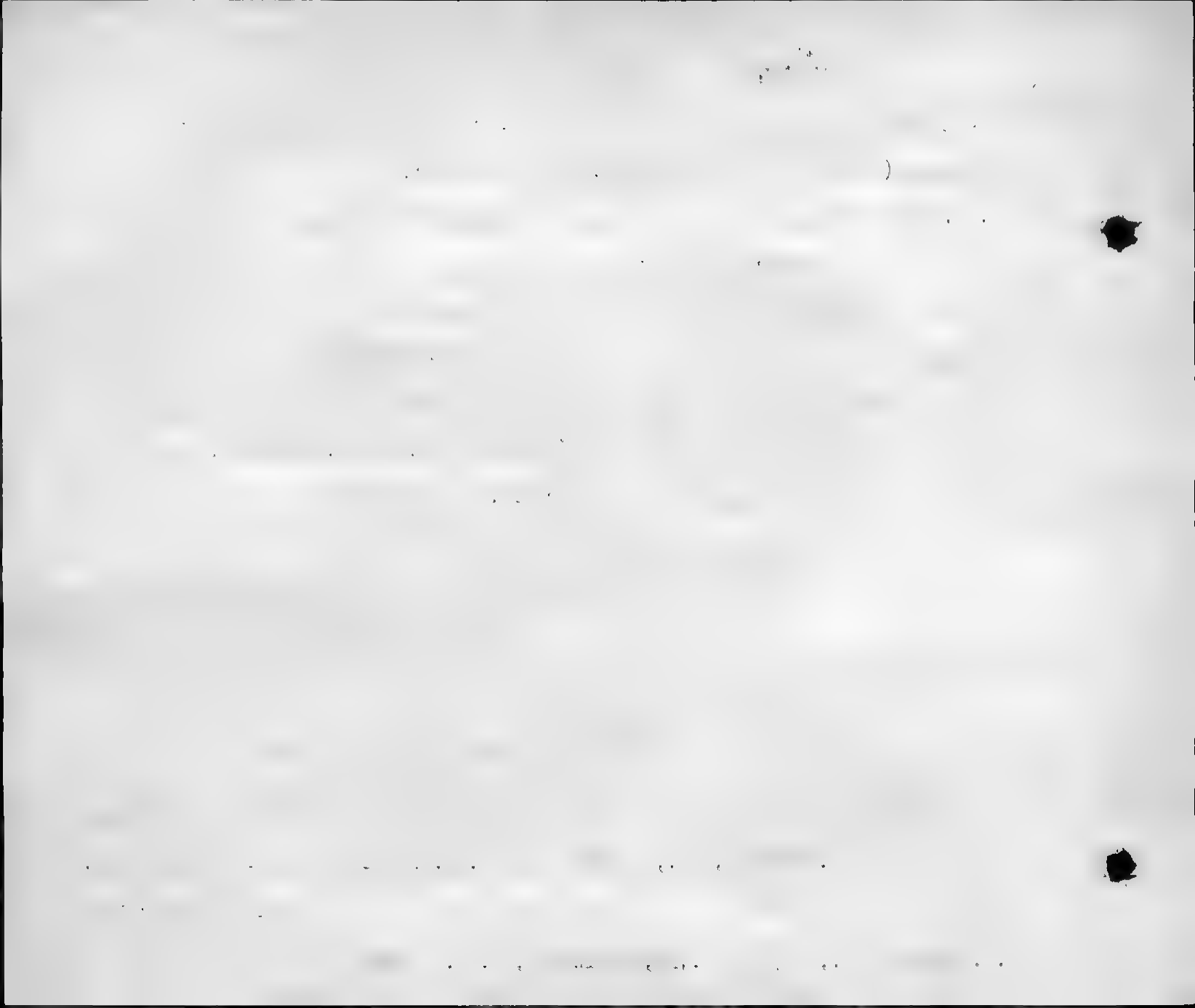
MEDICAL CERTIFICATION



3379

Arthur L. Kraus

VR A15 (4)  
15M 9/60





1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o STATE <u>Virginia</u> b COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>723-22nd St. S.</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche</u> First <u>Thomas</u> Middle <u>Thomas</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Cleveland Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William? Hewes</u>	
14. MOTHER'S MAIDEN NAME <u>Cassella Baldwin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> If yes, give war or dates of service <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction left Lung</u> <u>450.10</u> DUE TO (b) <u>Fall &amp; fracture to left chest wall</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Smile given ant. Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-25-1954</u> to <u>3-12-1961</u> , that (I) (we) lost saw the deceased alive on <u>12 Mar 1961</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>John B. Ziegler</u> M.D.		22b. DATE SIGNED <u>March 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		22d. ADDRESS <u>Olney, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 15 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>	23d. LOCATION (City, town, or county) (State) <u>Laytonsville Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 16 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>



may be filed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

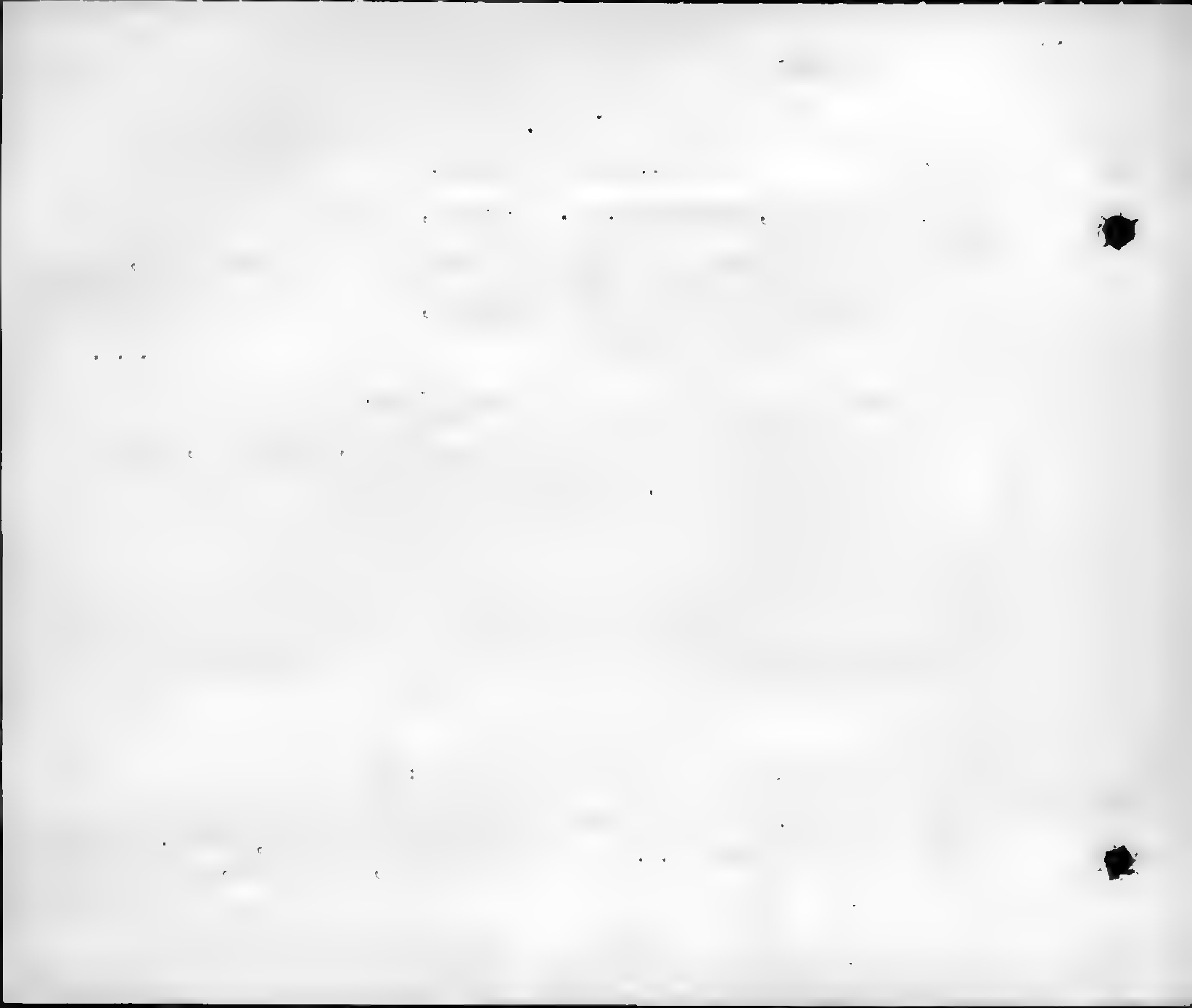
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3381

03370

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Prince William</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b>			
c. LENGTH OF STAY IN 1b <b>11 days</b>				d. STREET ADDRESS <b>Route 1, Box 69</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Teresa</b> Middle <b>Lynn</b> Last <b>Thurston</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1961</b>	
9. AGE (in years last birthday) <b>2</b> yrs		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.		IF UNDER 24 HRS Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Louis Thurston</b>				14. MOTHER'S MAIDEN NAME <b>Janice Bourne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>The Medical Record</b>			
17. INFORMANT <b>The Clinical Center, Bethesda 14, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Right Heart Failure</b> <b>587-2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cy. tic Fibrosis of Pancreas</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>One Hour</b> <b>2 Months</b> <b>2 Days</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>February 20, 1961</b> to <b>March 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1961</b> , and that death occurred at <b>3:05AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip Fireman</b> M.D.				22b. DATE SIGNED <b>3/3/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Philip Fireman M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Mar 5-1961</b>		<b>Dunquies</b>		<b>Dunquies Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hall Funeral Home, Celoguan, Va</b>				25a. RECEIVED BY REGISTRAR <b>MAR 17 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kucera</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3382

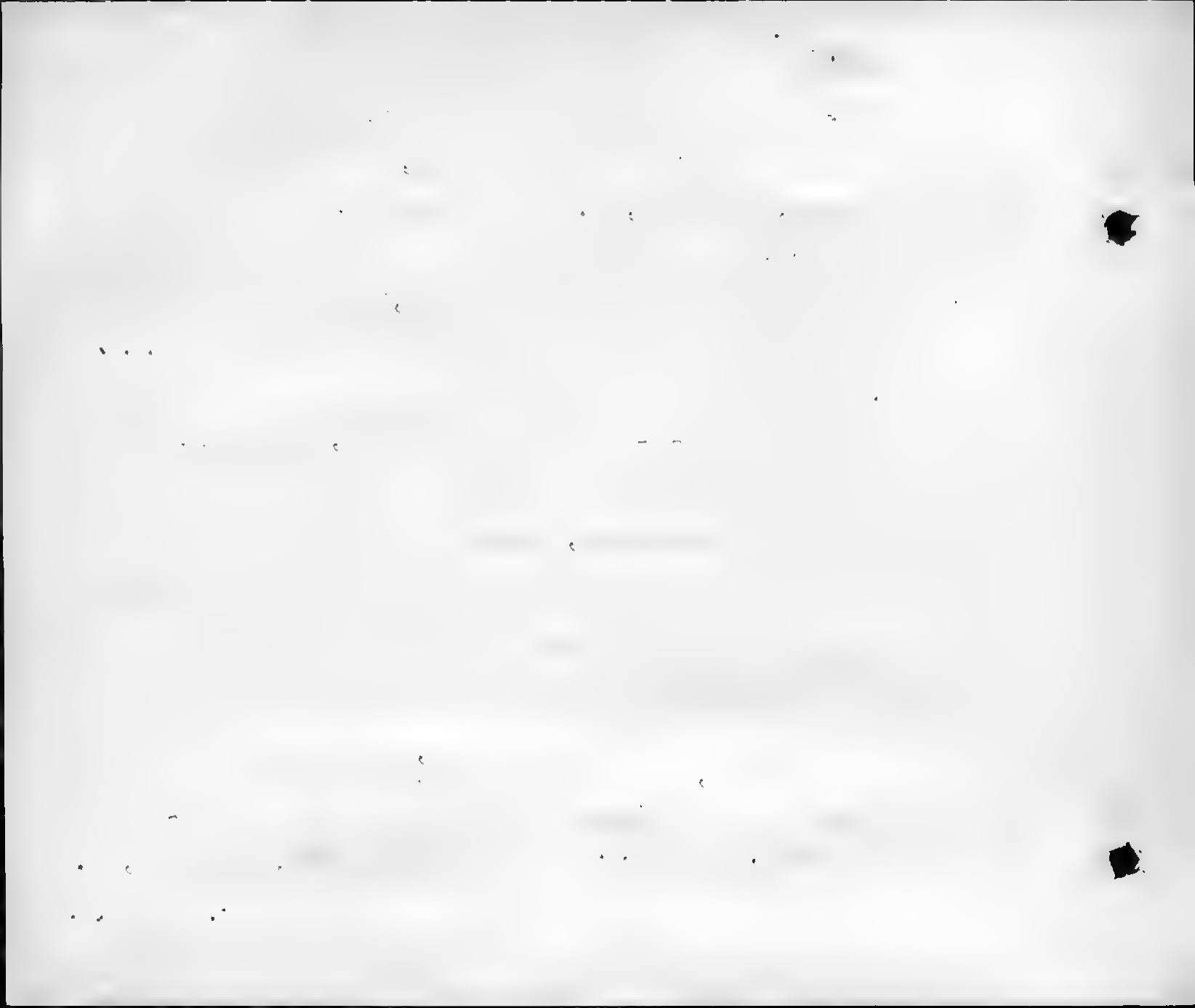
03371

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>209 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3467 Fish Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Trandafilos</b> Middle <b>Ralph</b> Last <b>Traikos</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 15, 1915</b>	
9. AGE (In years last birthday) <b>45</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>A. Casto Traikos</b>				14. MOTHER'S MAIDEN NAME <b>Athena Geranderos</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO <b>WW 11 086-10-7189</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chondrosarcoma, Extensive</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>3 Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>September 2, 1960</b> to <b>March 30, 1961</b> that (I) (we) last saw the deceased alive on <b>March 30, 1961</b> and that death occurred at <b>4:10 PM</b> on the causes and on the date stated above							
22a. SIGNATURE <b>Haskins K. Kashima</b> M.D.				22b. DATE SIGNED <b>3-30-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Haskins K. Kashima M.D.</b>				22d. ADDRESS <b>National Institutes Of Health The Clinical Center, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/31/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bronx. N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Niles Co.</b>				ADDRESS <b>2901-14th St. N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 3 61</b>	
				25b. REGISTRAR'S SIGNATURE <b>William L. Hanna</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3383 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03372

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md. Silver Spring 6 Years  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4010 Harvard St. Harvard St.

2. USUAL RESIDENCE (Where deceased lived, if institution, Res. dence before adm.ss on)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md. Silver Spring  
d. STREET ADDRESS 4010 Harvard St. Harvard St.

3. NAME OF DECEASED (Type or print) John Crawford Turner  
4. DATE OF DEATH March 20th 1961  
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH January 28, 1886 9. AGE (In years, last birthday) 75 yrs. IF UNDER 1 YEAR: Months Days Hours M.n.  
10. USUAL OCCUPATION (Give kind of work done during most of work life) Retired M/Sgt 10b. KIND OF BUSINESS OR INDUSTRY Soldier's home 11. BIRTHPLACE (State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 16. SOCIAL SECURITY NO. 113-20-9434 17. INFORMANT Mrs. Blanche Turner Address 4010 Harvard St. Rockville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  
PART I. DEATH WAS CAUSED BY:  
420.1 DUE TO Coronary occlusion  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

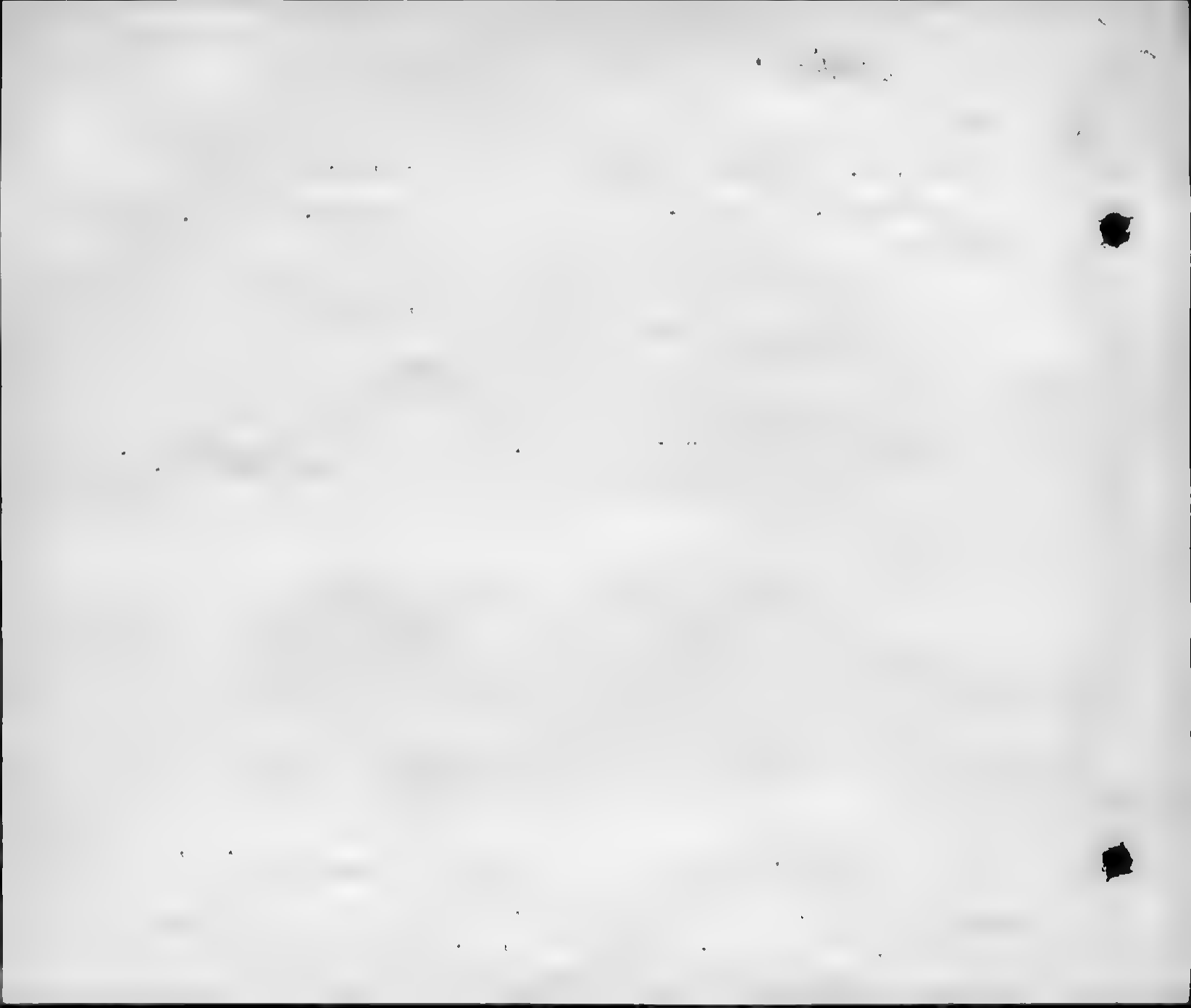
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19 3/24/61 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) Frank J. Broschart ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED Mar. 21, 1961  
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3/24/61 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY 22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR WERNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR MAR 27 '61 24b. REGISTRAR'S SIGNATURE Anthony S. Kraus





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. Then please remove carbon papers. Pages 3 and 4 should be detached for use as the burial-transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3384

CERTIFICATE OF DEATH

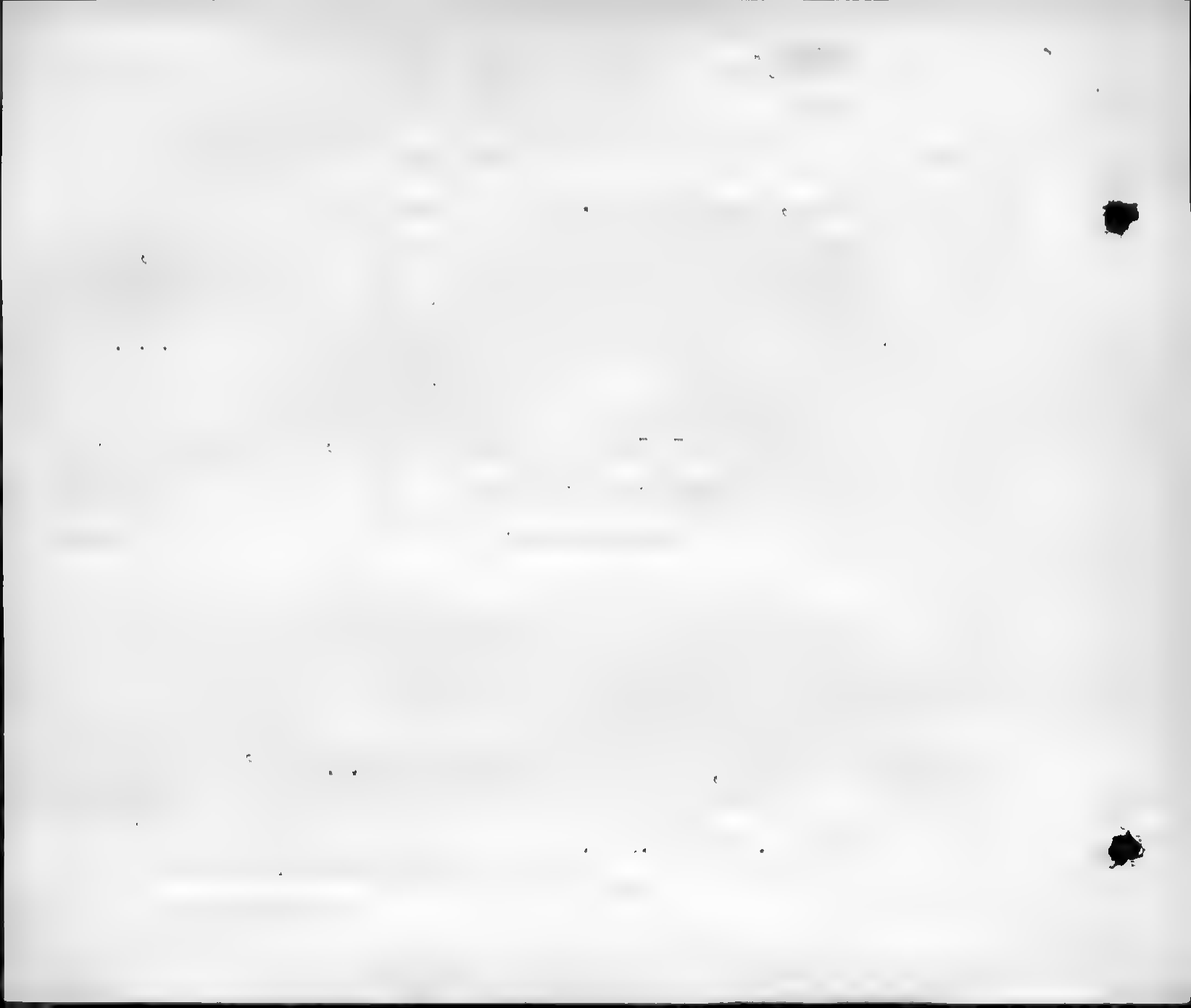
Items 10b, 10c, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

03373

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>86 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Thunderbolt</b>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Franklin</b> Last <b>Unglesbee</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 61</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 18, 1908</b>
9. AGE (In years last birthday) <b>52</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifford Unglesbee</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Warfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-21-0442</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple myeloma</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>6 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>December 5, 1960</b> to <b>March 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 1, 1961</b> and that death occurred on <b>March 1, 1961</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Vincent H. Bono Jr.</b>		22b. DATE SIGNED <b>3/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>VINCENT H. BONO, JR., MD.</b>		22d. ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	23b. DATE THEREOF <b>3/3/61</b>	23c. NAME OF BURIAL OR CREMATION <b>Abby Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Savannah, Georgia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		DATE <b>MAR 2 '61</b>	

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1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3385

## CERTIFICATE OF DEATH

Reg. Dist. No. 03374

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>07 Gaithersburg,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ward</b>				4. DATE OF DEATH Month Day Year <b>March 15, 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1961</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Carlton Wendell Ward</b>				14. MOTHER'S MAIDEN NAME <b>Sandra - Norson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Anoxia</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Partial Separation of Placenta</b> DUE TO (c) <b>3 days</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Wallace H. McCune</b>				M. D. <b>911 Silver Spring Ave., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wallace H. McCune, M. D.</b>				<b>911 Silver Spring Ave., Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 16 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Woodfield Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	
				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '61</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**3386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Items 22b, c & d Film G-203 3-22-61 ink 03375

1. PLACE OF DEATH  
a. COUNTY MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY in 1b 8.0 A.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanit Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Wash. D.C.  
b. COUNTY Wash. D.C.  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 143 Rhode Island Ave  
d. STREET ADDRESS Watts

3. NAME OF DECEASED (Type or print) Gilliam  
First Gilliam Middle Gilliam Last Gilliam

4. DATE OF DEATH  
Month 3 Day 20 Year 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH  
Month 12 Day 9 Year 10

9. AGE (In years last birthday) 50 yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labour 11. BIRTHPLACE (State or foreign country) GEORGIA

12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME James Watts 14. MOTHER'S MAIDEN NAME Mrs. Betty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. HOPE RECORD 17. INFORMANT HOPE RECORD Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE AND LACERATIONS  
DUE TO (b) MULTIPLE COMPOUND FRACTURES OF SKULL  
DUE TO (c) FALL FROM SCAFFOLD  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell 22 ft from scaffold on construction job

20c. TIME OF INJURY Month, Day, Year 2:00 p.m. 3-20 1961 20d. INJURY OCCURRED While ☒ at work Not While ☐ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) school construction Takoma Park County Md 20f. (City or town) (County) (State)

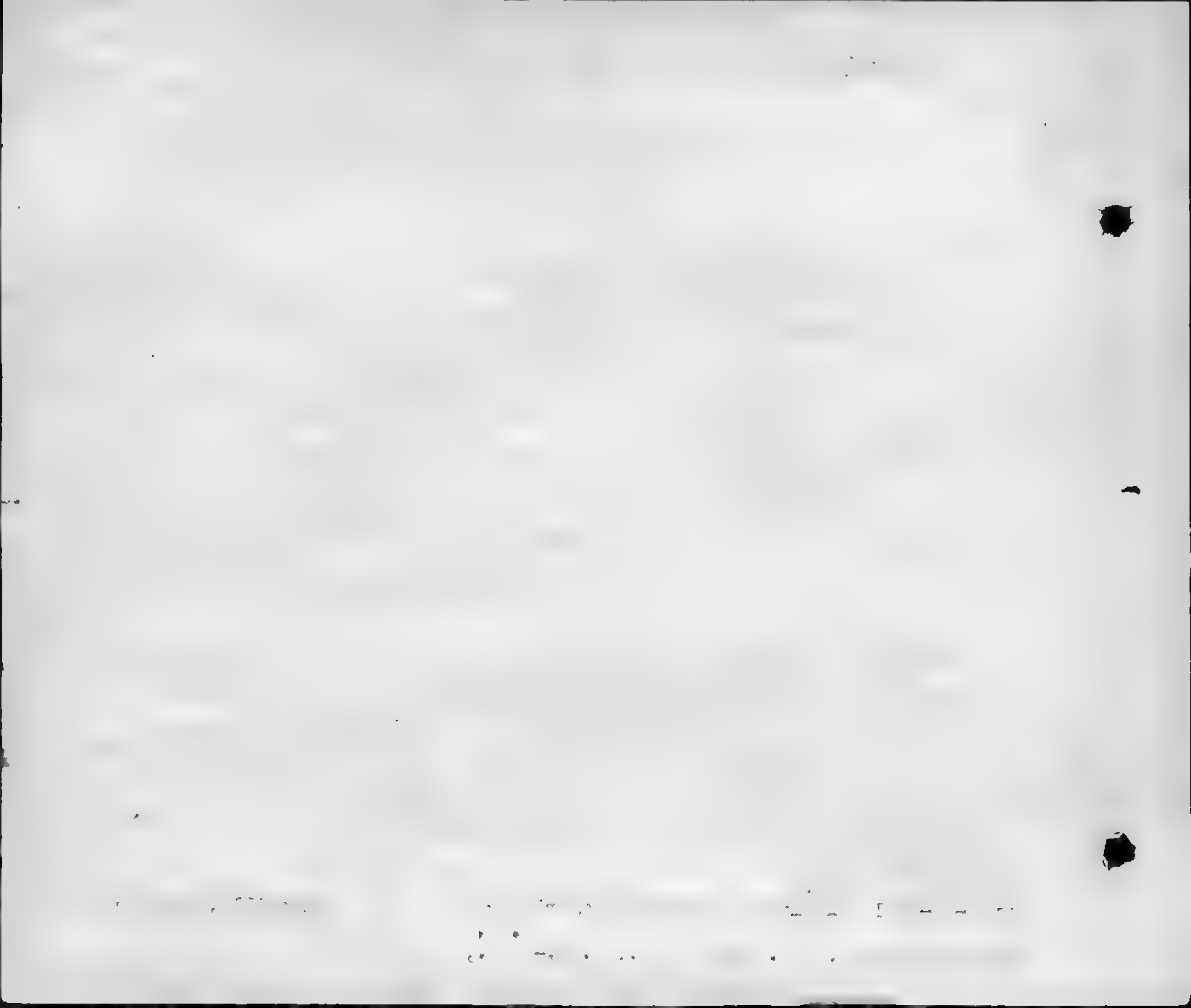
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Boschert M.D. CHIEF MEDICAL EXAMINER ☐ ASS. STANT MEDICAL EXAMINER ☐ DATE SIGNED 3-20-61

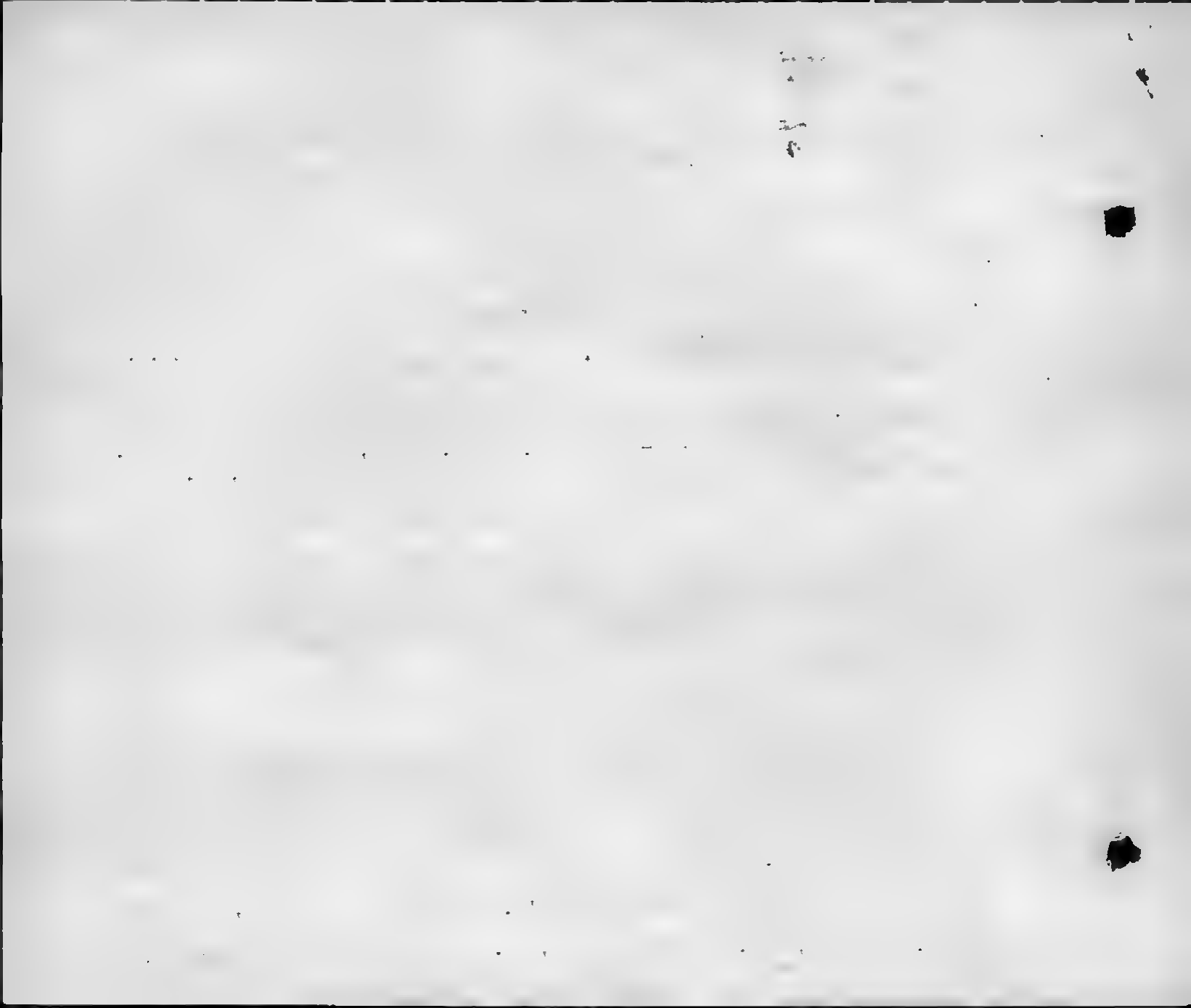
EXAMINER'S NAME (Type) FRANK J. BOSCHERT DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) 4611 Bevington Rd. E. Wash. D.C.

22a. BURIAL CREMATION Burial 22b. DATE THEREOF 3-24-1961 22c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park 22d. LOCATION (City, town, or country) (State) Huntville, Maryland

23. FUNERAL DIRECTOR MALVAN & SCHEY, INC. 424 "R" St., N. W.-Wash., ADDRESS D. C. 24a. REC'D BY REGISTRAR MAR 24 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hume









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

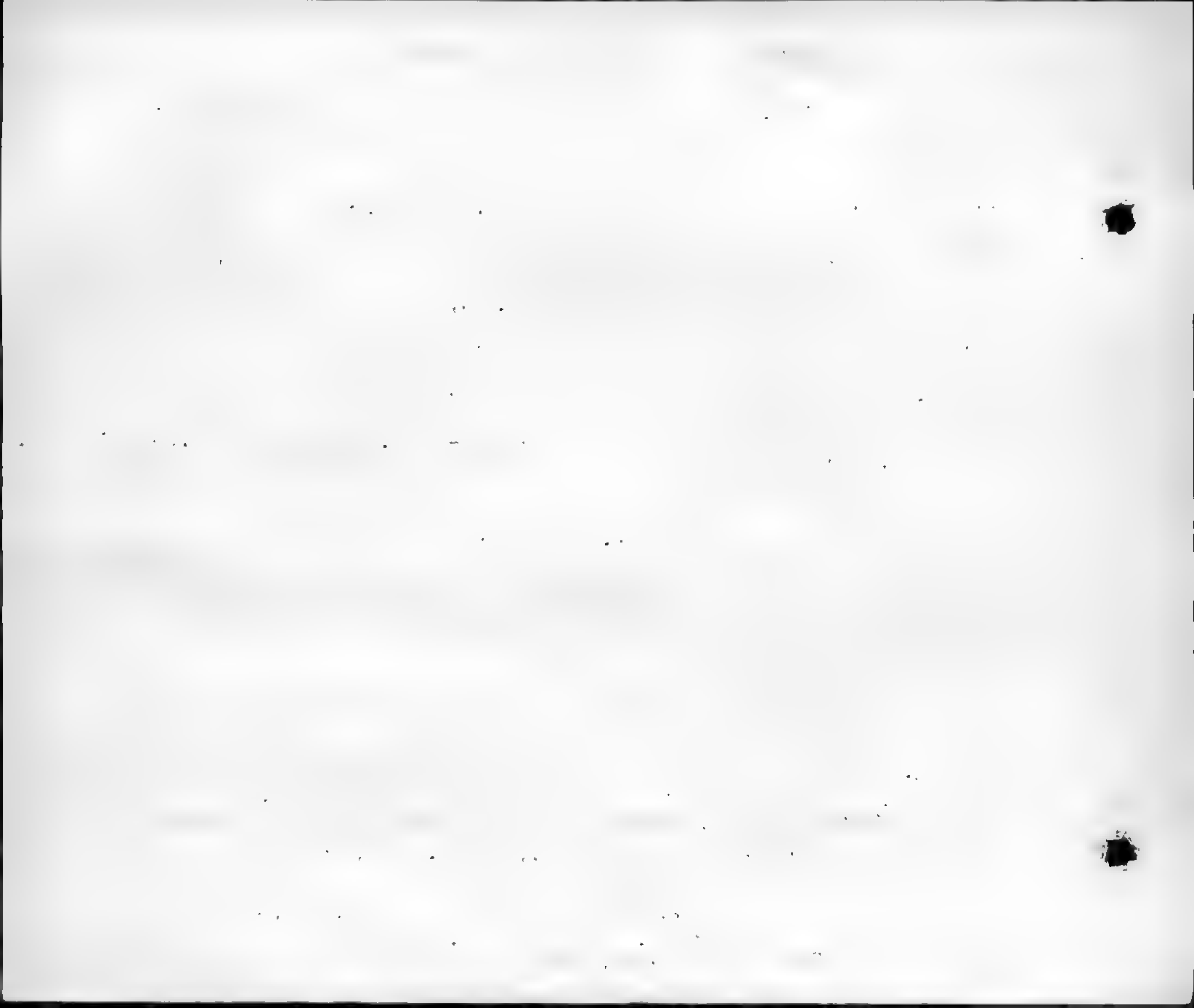
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3388

## CERTIFICATE OF DEATH

Reg. Dist. No. 03377

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>614 Pershing Drive</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>614 Pershing Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY RAY WATERS WELDEN</b> First Middle Last		4. DATE OF DEATH <b>March 15, 1961</b> Month Day Year	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1924</b>
9 AGE (In years last birthday) <b>36</b> yrs.		10 IF UNDER 1 YEAR Months Days Hours Min.	11 IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John B. Waters</b>	
14 MOTHER'S MAIDEN NAME <b>Mary Aileen Ray</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO		INFORMANT <b>Ryder Ray-200 N. Stonestreet Ave., Rockville, Md.</b> Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia</b> <b>577</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last (b) <b>gastro intestinal hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 11, 1959</b> , to <b>March 15, 1961</b> , that I last saw the deceased alive on <b>March 14, 1961</b> , and that death occurred at <b>1:15 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8237 Georgia Ave Silver Spring, Md</b> DATE SIGNED <b>3/16-61</b> ACTUAL SIGNATURE <b>Aaron H. Traum</b> PHYSICIAN'S NAME (Type) <b>Aaron Traum - 8237 Georgia Ave., Silver Spring, Maryland</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/18/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grace Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodside, Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Lyson Wheeler Funeral Home</b> ADDRESS <b>1331 E. Montgomery Ave. Rockville, Maryland</b>		24a REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	24b REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

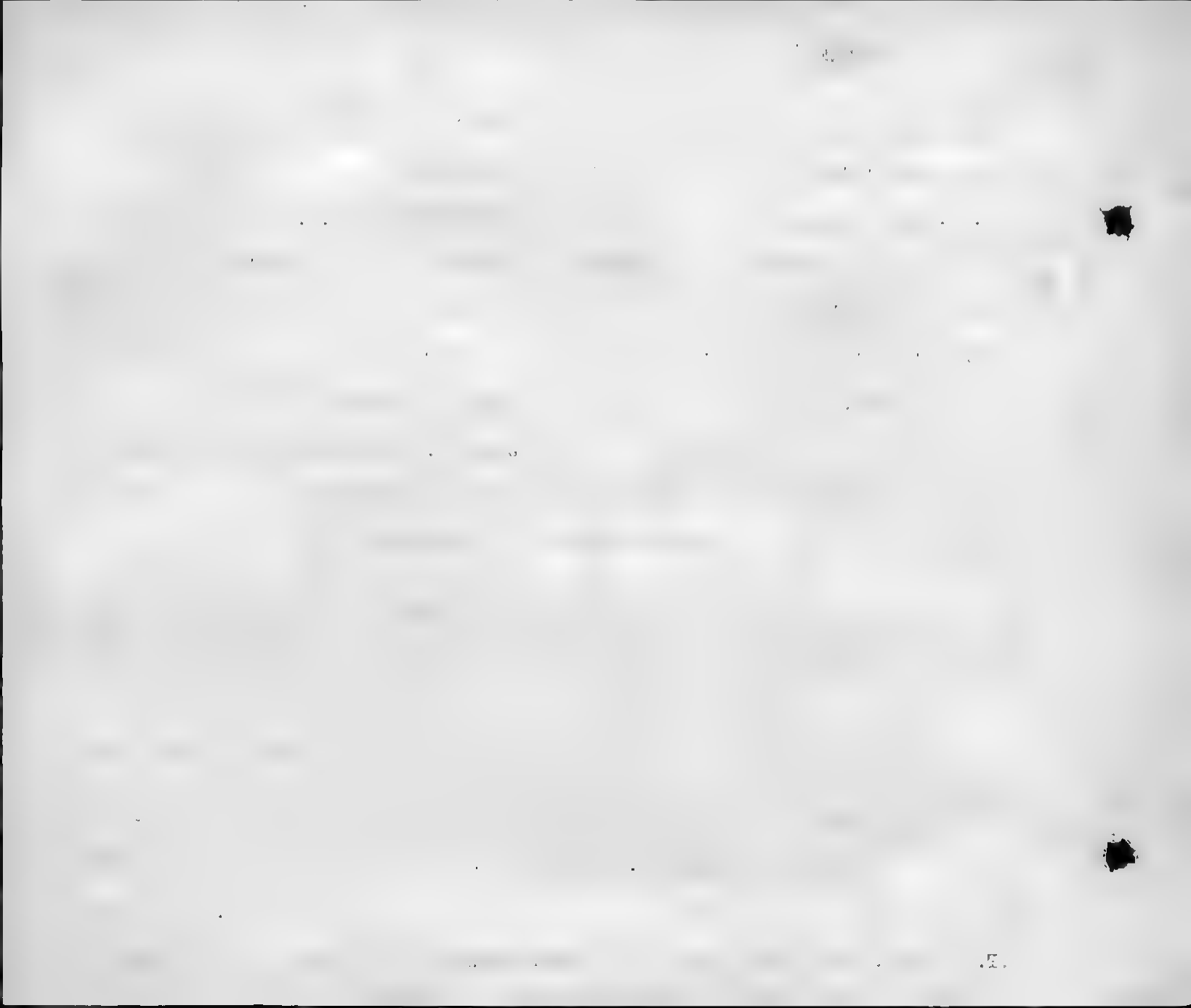
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3389

## CERTIFICATE OF DEATH

03378

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>54 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2633 12th St., N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Martha Coleman WOOTEN</u>		4. DATE OF DEATH <u>March 15 1961</u> Last Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-04</u>	
9. AGE (In years last birthday) <u>56 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert WALSTON</u>		14. MOTHER'S MAIDEN NAME <u>Martha J. COBURN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(S) James A. Wooten, same as #2 above</u>	
17. INFORMANT <u>(S) James A. Wooten, same as #2 above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure &amp; meningitis</u> DUE TO (b) <u>Carcinoma of the Cervix.</u> DUE TO (c) <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>Jan. 20</u> , 19 <u>61</u> to <u>March 15</u> , 19 <u>61</u> , that (X) (we) last saw the deceased alive on <u>March 15</u> , 19 <u>61</u> , and that death occurred at <u>3A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur O. Anctil, Jr.</u> M.D.		22b. DATE SIGNED <u>3-15-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur O. ANCTIL, JR., LT, MC, USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <u>Edgecombe Co. No. Carolina</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.T. Rhines</u> ADDRESS <u>3015 12th St. NE, WashDC</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 21 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03379

3390

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN 1b <b>4 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KENSINGTON GARDENS NURSING HOME</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>NEW YORK</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW YORK CITY</b> d. STREET ADDRESS <b>89X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT RALEIGH YATES</b>			<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>6</b> Year <b>19 61</b>				
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/10/85</b>		<b>9. AGE (in years last birthday)</b> <b>75</b> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CAPT. U. S. NAVY</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>WARRENTON, VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>HENRY CLAY YATES</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH DESHIELDS</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> <b>WW #2 &amp; WW #1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> Address <b>Mr. Benjamin R. Yates, Galleon House, St. Thomas Virgin Islands</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>PART I. DEATH WAS CAUSED BY:</b>  <b>3-4X</b> <b>Pneumonia</b>                      IMMEDIATE CAUSE (a) <b>Stroke</b>                      DUE TO (b) <b>Cerebral arteriosclerosis</b>                      Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Diabetes mellitus</b>                      DUE TO (c)                 </p> </div> <div style="width: 35%;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>3 days</b>  <b>710 days</b>  <b>Unknown</b> </p> </div> </div> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):</b>  <b>Diabetes mellitus</b> </p>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1957</b> <b>to</b> <b>3-6-</b> <b>1961</b> , <b>that (I) (the) last saw the deceased alive on</b> <b>3-6-</b> <b>1961</b> , <b>and that death occurred at</b> <b>5:17 p.m.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Morris Perry</b> <span style="float: right;">M.D.</span>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>MORRIS PERRY</b>				<b>22d. ADDRESS</b> <b>11602 Georgia Ave. Wheaton</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>CREMATION</b>		<b>23b. DATE THEREOF</b> <b>3/9/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FT. LINCOLN CREMATORY</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond A. Ziska</b>		<b>ADDRESS</b> <b>SILVER SPRING, MD</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5860

805

2000

1. *Prunella*  
 2. *Stachys*  
 3. *Salvia*  
 4. *Origanum*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**3391**

**03380**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carrollton</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Young</b>		4. DATE OF DEATH Month Day Year <b>march 12, 19 61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1961</b>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Charles William Young</b>				14. MOTHER'S MAIDEN NAME <b>Jeanetta Cora Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>father</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> <b>759.3</b> DUE TO <b>Congenital</b> Conditions, if any, which gave rise to immediate course (a), stating the <u>underlying</u> cause (b) <b>A Generalized edema (neck, body, scrotum)</b> lying cause lost. (c) <b>unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Herbert J. Friedel</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert J. Friedel, M. D.</b>				22d. ADDRESS <b>6826 Riggs Rd., Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D. Wash. San. &amp; Hospital</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

**2075333XV7**

I, the undersigned, a Minister of the Gospel, do hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_ 1950, at \_\_\_\_\_, in the County of \_\_\_\_\_, State of \_\_\_\_\_, the following persons were by me lawfully joined together in Holy Matrimony according to the rites and ceremonies of the \_\_\_\_\_ and the laws of the State of \_\_\_\_\_.

The bride was \_\_\_\_\_, of the County of \_\_\_\_\_, State of \_\_\_\_\_, and the groom was \_\_\_\_\_, of the County of \_\_\_\_\_, State of \_\_\_\_\_.

Witness my hand and the seal of my office this \_\_\_\_\_ day of \_\_\_\_\_, 1950.

\_\_\_\_\_

Minister of the Gospel